MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

00588

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Spring
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 2410 Eugene St

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE: Maryland COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Spring
STREET ADDRESS (If rural, give location): 2410 Eugene St.

**3. NAME OF DECEASED: (Type or Print)** (First) Anne (Middle) Magoria (Last) Akers

**4. DATE OF DEATH:** (Month) Jan (Day) 22 (Year) 1953

**5. SEX:** F

**6. COLOR OR RACE:** W

**7. SINGLE, MARRIED, WIDOWED, ~~DIVORCED~~, (Specify):** Widow

**8. DATE OF BIRTH:** Nov. 8, 1881

**9. AGE last birthday:** 71 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY:** Own Home

**11. BIRTHPLACE** (State or foreign country): Virginia

**12. CITIZEN OF WHAT COUNTRY?** U.S.A.

**13. FATHER'S NAME:** John B. Weaver

**14. MOTHER'S MAIDEN NAME:** Elmira Pettit

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) No — (If Yes, give war or dates of service) No

**16. SOCIAL SECURITY NO.:** None

**17. INFORMANT & ADDRESS:** Evelyne Clagett 1440 Rhode Island Ave NW. Wash. D.C.

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Coronary Occlusion | 50 Minutes |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last | DUE TO (b) Arterio-sclerosis, general, Marked | 15 years |
| | DUE TO (c) Hypertension | 15 years |
| | Diabetes Mellitus | 2 wks. |

420.1
260

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:**

**19b. MAJOR FINDINGS OF OPERATION:**

**20. AUTOPSY?** Yes ☐ No ☒

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 22, 1953, to Jan 22, 1953, that I last saw the deceased alive on Jan. 22, 1953, and that death occurred at 11:41 P. m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS — DATE SIGNED

George B. Patrick, Jr., M.D. 8700 Colesville Rd. Silver Spring, Md. 1-23-53

| 23. BURIAL, CREMATION REMOVAL (Specify): | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | 1/25/53 | Cedar Hill Cem | Suitland | Maryland |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 1-23-53 | Frances Potter | The D.H. Hines Co. | 3501-14th Wash. D.C. |

VS. A15 ... 51

RECEIVED
JAN 26 1953
BUREAU V. S.

Coroner Broschart, Montgomery
County, was called 11:50 P.M.
on 1-22-53 and said + authorized
me to sign death certificate.
1-23-53 George B. Patrick Jr. M.D.

under care of Dr. Herbert Martin, Jr.,
Washington, D.C. + I first saw
her 11:25 P.M. 1-22-53 JJP

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 010589

# CERTIFICATE OF DEATH

Reg. Dist. No. 223

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH:**
COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN Takoma Park | LENGTH OF STAY (in this place) 1 mo-12 das
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Sanitarium + Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE Virginia COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newport News
STREET ADDRESS (If rural give location) 911 21st Street

**3. NAME OF DECEASED:** (Type or Print) (First) Mrs (Middle) Willian (Last) Abers

**4. DATE OF DEATH:** (Month) 1 (Day) 13 (Year) 1953

**5. SEX:** Male

**6. COLOR OR RACE:** Caucasian

**7. SINGLE, MARRIED, WIDOWED, DIVORCED** (Specify): Married

**8. DATE OF BIRTH:** 5-4-85

**9. AGE** Last birthday: 67 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

**10a. USUAL OCCUPATION.** Give kind of work done during most of working life, even if retired): Salesman

**10b. KIND OF BUSINESS OR INDUSTRY:** Abers Beverage Co.

**11. BIRTHPLACE** (State or foreign country): Franklin Co. Virginia

**12. CITIZEN OF WHAT COUNTRY?** U.S.A.

**13. FATHER'S NAME:** William H. Abers

**14. MOTHER'S MAIDEN NAME:** May Lavender

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) No | (If Yes, give war or dates of service) —

**16. SOCIAL SECURITY NO.:**

**17. INFORMANT & ADDRESS:** Hospital Records

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset And Death |
|---|---|---|
| Immediate cause | (a) Cerebral Accident | 6 hours |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. | DUE TO (b) arteriosclerosis | 4 yrs. |
| | DUE TO (c) | |

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:** | **19b. MAJOR FINDINGS OF OPERATION** | **20. AUTOPSY?** Yes ☐ No ☐

**21.** ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-20, 1952, to 1-13-53, 19..., that I last saw the deceased alive on 1-20, 1953 and that death occurred at 2.20 am., from the causes and on the date stated above.

SIGNATURE AND (Degree or title) I-12 [illegible] MD — ADDRESS Takoma Park Md — DATE SIGNED 1/13/53

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF — | NAME OF CEMETERY OR CREMATORY Greenlawn | LOCATION (City, town, or county) Newport News, Va. (State)

DATE REC'D BY LOCAL REGISTRAR Jan-13-1953 | REGISTRAR'S SIGNATURE J. Wilson Dodd

24. FUNERAL DIRECTOR Coffee Funeral Home — ADDRESS Newport News Va.

RECEIVED
JAN 15 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00590

# CERTIFICATE OF DEATH

Reg. Dist. No. 2 1 1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Montgomery; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Near Cedar Rock; LENGTH OF STAY (in this place) all his life; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montg; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Near Cedar Rock Road; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) WILLIE (Middle) J (Last) APPLEBY

4. DATE OF DEATH: (Month) Jan (Day) 24 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8a. DATE OF BIRTH: Dec 20 1868

9. AGE last birthday: 84 yrs.

If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Blacksmith - Shop

10b. KIND OF BUSINESS OR INDUSTRY: Own Business

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Appleby

14. MOTHER'S MAIDEN NAME: Lucy Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): —

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mary Appleby

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Bronchial pneumonia | 15 days |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Cerebral Thrombosis - | 1 hour |
| | (c) Arteriosclerotic Heart Disease | 10 years |

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II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: —

(CITY OR TOWN) —

(COUNTY) —

(STATE) —

TIME OF INJURY (Month) (Day) (Year) (Hour): — m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Jan., 1935, to Jan 25, 1953, that I last saw the deceased alive on Jan. 24, 1953, and that death occurred at 12:05 a. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) M. McCandrea Boyd M.D. ADDRESS Damascus, Maryland DATE SIGNED 1/25/53

23. BURIAL, CREMATION / REMOVAL (Specify): Burial

DATE THEREOF: Jan 27/53

NAME OF CEMETERY OR CREMATORY: Damascus Md

LOCATION (City, town, or county) (State): Montg Md

DATE REC'D BY LOCAL REG.: Jan 26/53

REGISTRAR'S SIGNATURE: Della W. Burdette

24. FUNERAL DIRECTOR: Roy W. Barnhart

ADDRESS: Poolesville Md

VS. A15

RECEIVED
JAN 28 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 111591 3/6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH:**
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN: Bethesda
LENGTH OF STAY (in this place): 2½ days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Suburban Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Kensington
STREET ADDRESS (If rural give location): 3927 Prospect Street

**3. NAME OF DECEASED:** (Type or Print) (First) Blanche (Middle) Carlton (Last) Armstrong

**4. DATE OF DEATH:** (Month) Jan. (Day) 4 (Year) 1953

**5. SEX:** Female

**6. COLOR OR RACE:** white

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):** widowed

**8. DATE OF BIRTH:** Nov. 3, 1871

**9. AGE last birthday:** 81 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY:**

**11. BIRTHPLACE** (State or foreign country): Massachusetts

**12. CITIZEN OF WHAT COUNTRY?** U.S.A.

**13. FATHER'S NAME:** Charles H. Knott

**14. MOTHER'S MAIDEN NAME:** Harrub

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) no (If Yes, give war or dates of service)

**16. SOCIAL SECURITY No.:** —

**17. INFORMANT & ADDRESS:** 2001 Shorefield Rd. Bradford Armstrong Silver Spring, Md.

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between Onset And Death

331 Immediate cause (a) Cerebral hemorrhage — 3 days

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) Arterial hypertension, and — Several Years

DUE TO (c) Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:** **19b. MAJOR FINDINGS OF OPERATION**

**20. AUTOPSY?** Yes ☐ No ☑

**21.** ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1953, to Jan 3, 1953, that I last saw the deceased alive on Jan 3, 1953, and that death occurred at 4 50 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Thomas A.H. Kindman M.D. — ADDRESS Kensington Md. — DATE SIGNED 1/4/53

**23. BURIAL, CREMATION, REMOVAL** (Specify): Burial — DATE THEREOF: 1-7-53 — NAME OF CEMETERY OR CREMATORY: Rockville Union — LOCATION (City, town, or county) (State): Rockville, Maryland

DATE REC'D BY LOCAL REGISTRAR: 1/5/53 — REGISTRAR'S SIGNATURE: Bessie M. Thompson — 24. FUNERAL DIRECTOR: Robert A. Dunphey — ADDRESS: Bethesda, Maryland

RECEIVED
JAN 7 1953
BUREAU V. S.

00592

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH**
COUNTY: MONTGOMERY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: KENSINGTON
LENGTH OF STAY (in this place): 49 YRS.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 3923 PROSPECT ST.

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: MARYLAND — COUNTY: MONTGOMERY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: KENSINGTON
STREET ADDRESS (If rural, give location): 3923 PROSPECT ST.

**3. NAME OF DECEASED** (Type or Print): (First) HUGH (Middle) — (Last) ARMSTRONG

**4. DATE OF DEATH**: (Month) 1 (Day) 24 (Year) 1953

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | MARRIED | APRIL 4 1875 | 77 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| PATENT EXAMINER | U.S. GOV'T. | INDIANA | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| WILLIAM STUART ARMSTRONG | JENNIE DONALDSON |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| NO | — | Wm. R. Armstrong - 7410 Pulle Dr. |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Rupture of Aneurysm of Abdominal Aorta | 2 yrs. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Hypertensive Cardio-Vascular-Renal Disease | 5 yrs + |
| | (c) | |

4427

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| — | — | — | — | — |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | — | — |

22. I hereby certify that I attended the deceased from ....., 1947, to Jan 24, 1953, that I last saw the deceased alive on Dec 26, 1952, and that death occurred at 6.00 a.m., from the causes and on the date stated above.

SIGNATURE: Stewart Adams (Degree or title) M.D. ADDRESS: 3921 Ingomar St. DATE SIGNED: Jan 24 '53

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1/27/1953 | Rockville Union | Rockville Maryland |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 1/24/53 | Lewis M. Humphreys | Robert A. Pumphrey | Bethesda, Md. |

County Coroner Notified & Has Cleared Case

RECEIVED
JAN 27 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS. A15

1. PLACE OF DEATH:
COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
MARYLAND
RURAL LENGTH OF STAY (in this place) 20 hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospital 9495 Bradley Blvd.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda.
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Marion (Middle) O'Connell (Last) Bell
4. DATE OF DEATH: (Month) Jan (Day) 26 (Year) 1953
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: 8-8-90
9. AGE last birthday: 62 yrs. IF UNDER 1 YEAR Months 5 Days 18 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: James O'Connell
14. MOTHER'S MAIDEN NAME: Ellen Gallagher.
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unk.) No
(If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: Mrs John H Jnoky 384d Keystone Ave. New York City

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardio-respir. failure — Interval Between Onset And Death: 30 min

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Pulmonary Emphysema, Corpulence — 2 yrs.
DUE TO (c) & Congestive Heart failure

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes No

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/1, 1952, to 1/26, 1953, that I last saw the deceased alive on 1/26, 1953, and that death occurred at 1 PM, from the causes and on the date stated above.
SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Stephen N. Jones M.D. Rockville, Md 1/26/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 1/28/1953
NAME OF CEMETERY OR CREMATORY Arlington National
LOCATION (City, town, or county) Arlington (State) Virginia
DATE REC'D BY LOCAL REGISTRAR 1/27/53
REGISTRAR'S SIGNATURE
24. FUNERAL DIRECTOR Robert A. Humphrey
ADDRESS Bethesda, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. [illegible]

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH:**

COUNTY [illegible] MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BETHESDA (RURAL)

LENGTH OF STAY (in this place) 7 Yrs-20 Days

HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. NAVAL HOSPITAL

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

STATE MARYLAND COUNTY [illegible]

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SILVER SPRING

STREET ADDRESS (If rural give location) 11510 College View Drive

**3. NAME OF DECEASED:** (Type or Print) (First) Arthur (Middle) Benton (Last) BENDER

**4. DATE OF DEATH:** (Month) January (Day) 13, (Year) 1953

**5. SEX:** MALE

**6. COLOR OR RACE:** WHITE

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):** DIVORCED

**8. DATE OF BIRTH:** 6 OCT. 1873

**9. AGE last birthday:** 79 yrs. IF UNDER 1 YEAR: Months | Days IF UNDER 24 HRS.: Hours | Min.

**10a. USUAL OCCUPATION** Give kind of work done during most of working life, even if retired): PIANIST

**10b. KIND OF BUSINESS OR INDUSTRY:** - - - - - - - - -

**11. BIRTHPLACE** (State or foreign country): OHIO

**12. CITIZEN OF WHAT COUNTRY?** U. S.

**13. FATHER'S NAME:** Thomas Benton BENDER

**14. MOTHER'S MAIDEN NAME:** Helen MERRILL

**15 WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) NO (If Yes, give war or dates of service) - - - - -

**16. SOCIAL SECURITY No.:** UNKNOWN

**17. INFORMANT & ADDRESS:** Son--- Merrill Arthur BENDER - Same as 2 above

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between Onset And Death

Immediate cause (a) DUE TO Cerebral Thrombosis — 12 hrs

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO Arteriosclerosis — 15-20 years

(c)

II OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:** **19b. MAJOR FINDINGS OF OPERATION**

**20. AUTOPSY?** Yes ☒ No ☐

**21.** ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-15-, 1952, to 1-13-, 1953., that I last saw the deceased alive on 1-13-, 1953, and that death occurred at 11:45 AM., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

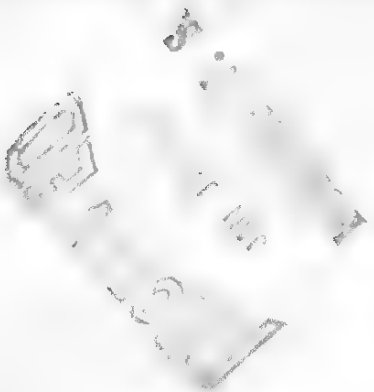
William T. Hall M.D. USNH, NNMC, Bethesda, Md. 1-14-53

**23. BURIAL, CREMATION, REMOVAL** (Specify) Cremation — DATE THEREOF 1-14-53 — NAME OF CEMETERY OR CREMATORY CEDAR HILL — LOCATION (City, town, or county) (State) SUITLAND MARYLAND

DATE REC'D BY LOCAL REGISTRAR 1-[illegible]-53 — REGISTRAR'S SIGNATURE Edith Whittington

**24. FUNERAL DIRECTOR** ADDRESS

Robert A. Pumphrey 7857 Wisconsin Ave., Bethesda, Maryland



MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cabin John; LENGTH OF STAY (In this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 9 McKay Circle

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montg.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cabin John; STREET ADDRESS (If rural, give location) 9 McKay Circle

3. NAME OF DECEASED (Type or Print): (First) ARCHIE (Middle) P. (Last) BOOTH

4. DATE OF DEATH: (Month) (Day) (Year) 1-18-1953 19

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 12/26/1902

9. AGE last birthday: 50 yrs. If under 1 year: Months 0, Days 22; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Montg. Co. Library

11. BIRTHPLACE (State or foreign country): Alabama

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Can Booth

14. MOTHER'S MAIDEN NAME: Martha Hodo

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY No.: 579-12-7307

17. INFORMANT AND ADDRESS: Mrs. Alma S. Booth-Sane Item, 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary occlusion — Interval between onset and death: 1 hr.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) [illegible] — 420.1

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

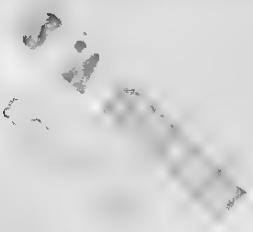
22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Paul J. Brochart M.D. Gaithersburg Md 1-19-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 1/23/1953 — NAME OF CEMETERY OR CREMATORY: Ft. Lincoln — LOCATION (City, town, or county) (State): Prince Geo. Co Md.

DATE REC'D BY LOCAL REG. 1/20/53 — REGISTRAR'S SIGNATURE [illegible] — 24. FUNERAL DIRECTOR: Roberts A. Humphrey — ADDRESS: Bethesda, Md.



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 16

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospt.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
STREET ADDRESS (If rural, give location) 4500 Harling Lane

3. NAME OF DECEASED (Type or Print): (First) [illegible] (Middle) W. (Last) [illegible]

4. DATE OF DEATH (Month) (Day) (Year) 19[illegible]

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 2-8-1906

9. AGE last birthday: 46 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Elect. Eng.

10b. KIND OF BUSINESS OR INDUSTRY: American Tel.& Telegraph Co.

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Roswell J. Bortner

14. MOTHER'S MAIDEN NAME: Rebecca O. Ottenniller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 172-01-2183

17. INFORMANT AND ADDRESS: Mary R. Bortner- Item 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Car[illegible]

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from [illegible], 19[illegible] to [illegible], 19[illegible], that I last saw the deceased alive on Jan 13, 19[illegible], and that death occurred at [illegible] m., from the causes and on the date stated above.

SIGNATURE [illegible] (Degree or title) ADDRESS [illegible] DATE SIGNED [illegible]

23. BURIAL, CREMATION / REMOVAL (Specify): Transit

DATE THEREOF: 1-21-53

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county) (State): York, Pennsylvania

DATE REC'D BY LOCAL REG. 1-20-53

REGISTRAR'S SIGNATURE [illegible]

24. FUNERAL DIRECTOR: Robert H. Handley ADDRESS: Bethesda, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town) Bethesda
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE D.C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural give location) 3212 Morrison St. NW

3. NAME OF DECEASED: (Type or Print) (First) JAY (Middle) HINCKLEY (Last) BOWKER

4. DATE OF DEATH: (Month) Jan (Day) 5 (Year) 19 53

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M

8. DATE OF BIRTH: March 22, 1876

9. AGE last birthday: 76 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Accountant

10b. KIND OF BUSINESS OR INDUSTRY: Government

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: ERI Bowker

14. MOTHER'S MAIDEN NAME: Sarah Ellen Woodard

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Wife

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset And Death |
|---|---|---|
| Immediate cause | (a) Bronchopneumonia | 6 days |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. | (b) DUE TO Cerebral Arteriosclerosis | 5 yrs. |
| | (c) DUE TO Generalized Arteriosclerosis | 5 yrs. |

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Benign prostatic hypertrophy

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

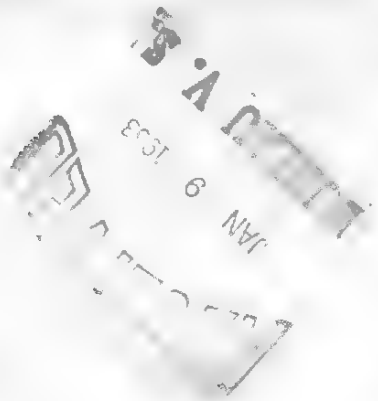
22. I hereby certify that I attended the deceased from Oct ..., 1952, to Jan 5 ..., 1953, that I last saw the deceased alive on Jan 5, 1953, and that death occurred at 7:25 PM, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
George Sharpe M.D. 10644 Conn. Ave Kensington, Md. Jan 5, 1953

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 1-8-53
NAME OF CEMETERY OR CREMATORY Rock Creek
LOCATION (City, town, or county) Washington, D.C. (State)
ADDRESS

DATE REC'D BY LOCAL REGISTRAR 1/7/53
REGISTRAR'S SIGNATURE
24. FUNERAL DIRECTOR Robert A. Dunphey Bethesda, Md.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Silver Spring
LENGTH OF STAY (in this place) 9 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS 702 Gist St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md — COUNTY Montgom
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
STREET ADDRESS (If rural, give location) 702 Gist St

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Catherine (Last) Brady

4. DATE OF DEATH: (Month) Jan (Day) 9 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow.

8. DATE OF BIRTH: Feb 14 1863

9. AGE last birthday: 89 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY: U.S.

13. FATHER'S NAME: William Mathew Davis

14. MOTHER'S MAIDEN NAME: Anna E. Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: No

17. INFORMANT AND ADDRESS: Marion D Kallert - granddaughter

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Arteriosclerotic Heart Disease — Interval Between Onset and Death: 2 yrs

420.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Fracture of both hips — 28 months

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): None

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) None m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1952, to Jan 8, 1953, that I last saw the deceased alive on Jan. 8, 1953, and that death occurred at 9:45 A m., from the causes and on the date stated above.

SIGNATURE: A. H Traum M.D. by Wm. C. Perry M.D. (Degree or title) ADDRESS 10113 Georgia Ave. Silver Spring, Md. DATE SIGNED Jan 9 53

23. BURIAL, CREMATION, REMOVAL (Specify): Removal — DATE THEREOF: Jan. 9, 1953 — NAME OF CEMETERY OR CREMATORY — LOCATION (City, town, or county) (State): Woodington, D.C.

DATE REC'D BY LOCAL REG. 1-9-53 — REGISTRAR'S SIGNATURE: Frances Potter

24. FUNERAL DIRECTOR: Lee Funeral Home — ADDRESS: 330 - 4th St NE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

**1. PLACE OF DEATH:**

COUNTY [illegible] MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: BETHESDA (RURAL)

LENGTH OF STAY (in this place): 6 Mos-6 Days

HOSPITAL OR INSTITUTION OR STREET ADDRESS: U. S. Naval Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

STATE [illegible] COUNTY [illegible]

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: STEELTON

STREET ADDRESS (If rural give location): 24 Pine Street

**3. NAME OF DECEASED:** (Type or Print) (First) Jos[illegible] (Middle) Ellwood (Last) BRINTON

**4. DATE OF DEATH:** (Month) January (Day) 14, (Year) 19 53

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| MALE | WHITE | WIDOWED | January 30, 1892 | 60 yrs. | | | | |

| 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| BRICKLAYER | Home-Construction | OHIO | U. S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| George Ellwood BRINTON | Annie Deborah NOBLE |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT & ADDRESS |
|---|---|---|---|
| YES | WWI | 134-07-1245 | Sister: Mrs. Walter STABNAU - Same as 2 above |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset And Death |
|---|---|---|
| Immediate cause | (a) Generalized Carcinomatosis | 6 mo |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. | (b) DUE TO Bronchogenic Carcinoma | 2 yrs |
| | (c) DUE TO | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes X No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. I hereby certify that I attended the deceased from 1-3-, 19 52, to 1-14-, 19 53, that I last saw the deceased alive on 1-14-, 19 53, and that death occurred at 4:00 AM, from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| William E Carter | MD | U.S. Naval Hospital, Bethesda, Md. | 1-[illegible]-53 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| [illegible] | 1-15-53 | OAKRIDGE | Steelton | Pennsylvania |

| DATE REC'D BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 1-[illegible]-53 | Enid Whittington | R. A. Pumphrey | 107 [illegible] Ave., Bethesda, Maryland |

JAN 1
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 217

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Montg — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN: Olney
LENGTH OF STAY (in this place): 2 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Briarke Brook Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Wash — COUNTY D.C.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN:
STREET ADDRESS (If rural give location): 1420 Longfellow St N.W.

3. NAME OF DECEASED: (First) Georgie (Middle) Taylor (Last) Bronaugh
4. DATE OF DEATH: (Month) Jan (Day) 4 (Year) 1953
5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):
8. DATE OF BIRTH: Feb 26, 1866
9. AGE last birthday: 86 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housekeeper
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John C Bronaugh
14. MOTHER'S MAIDEN NAME: Sallie Taylor
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: MRS. A. T. Bronaugh

18. MEDICAL CERTIFICATION

| | | Interval Between Onset And Death |
|---|---|---|
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | |
| Immediate cause | (a) Hypostatic pneumonia | 1 wk |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. | DUE TO (b) Generalized arteriosclerosis | 10 yrs |
| | DUE TO (c) Senile degeneration | 15 yrs |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | |

420.1

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. , 1952, to Jan. , 1953, that I last saw the deceased alive on Jan 2 , 1953, and that death occurred at 3:55 P.M., from the causes and on the date stated above.
SIGNATURE: Dr Bonifant (Degree or title): M.D. ADDRESS: Forest Spring Md DATE SIGNED: 1-4-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Jan 7-53
NAME OF CEMETERY OR CREMATORY: Congressional Cem
LOCATION (City, town, or county) (State): Washington DC
DATE REC'D BY LOCAL REGISTRAR: 1-4-53
REGISTRAR'S SIGNATURE: Gertrude B Fawley
24. FUNERAL DIRECTOR: J. Wm. Lee Funeral Co. ADDRESS: 300 - 4th St NE

RECEIVED
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda; MARYLAND; LENGTH OF STAY (In this place) 2 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Monty; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington; STREET ADDRESS (If rural, give location) 3910 Hartford St

3. NAME OF DECEASED (Type or Print): (First) Cecil (Middle) [illegible] (Last) Brown

4. DATE OF DEATH: (Month) 1 (Day) 8 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: col

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: June 15

9. AGE last birthday: 42 yrs. If under 1 year: Months / Days / If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): [illegible] worker

10b. KIND OF BUSINESS OR INDUSTRY: [illegible] Montgomery Co

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Walter Brown md

14. MOTHER'S MAIDEN NAME: Catherine Chase md

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS

### 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

954X (47.X)

**Immediate cause** (a) Respiratory failure while under sodium pentothal anesthesia following operation for left inguinal hernia due to collapse of left lung

**Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) [illegible]

(c) Lobar pneumonia (Rt lower lobe)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 1-8-53

19b. MAJOR FINDINGS OF OPERATION: left inguinal hernia

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy* ☒, *Inspection* ☐, *Inquiry* ☐ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE (Degree or title): Frank J. Bonestart M.D. ADDRESS: Gaithersburg md DATE SIGNED: 1-8-53

23. BURIAL, CREMATION, REMOVAL (Specify): Cremation DATE THEREOF: Jan 12 1953 NAME OF CEMETERY OR CREMATORY: Brownstown LOCATION (City, town, or county) (State): Germantown Md.

DATE REC'D BY LOCAL REG. 1/12/53 REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR [illegible] Robert Sugarman ADDRESS Rockville

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 212

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 51

1. PLACE OF DEATH:
COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Martinsburg
MARYLAND LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Hackerson, R.F.D.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Martinsburg
STREET ADDRESS (If rural, give location) Hackerson. R.F.D.

3. NAME OF DECEASED: (First) Robert (Middle) Bruner (Last)

4. DATE OF DEATH: (Month) Jan. (Day) 8, (Year) 1953

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widower

8. DATE OF BIRTH: Dec. 21, 1870

9. AGE last birthday: 82 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Farm Labor

11. BIRTHPLACE (State or foreign country): Martinsburg, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ike Bruner

14. MOTHER'S MAIDEN NAME: Frances Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Williamena Smith (Daughter)

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Pulmonary Tuberculosis — Interval between onset and death: 6 to 8 year

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO (b)

DUE TO (c) Tuberculosis — 8 year

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Congestive Heart Failure — 2 weeks

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 1952, to 8 Jan., 1953, that I last saw the deceased alive on 8 Jan., 1953, and that death occurred at 4:30 P m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED
Gordon M. Smith M.D. Barnesville 9 Dec 53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF 1/13/53
NAME OF CEMETERY OR CREMATORY Martinsburg
LOCATION (City, town, or county) (State) Martinsburg, Md

DATE REC'D BY LOCAL REG. Jan. 13 1953
REGISTRAR'S SIGNATURE Charles E. Eglin
24. FUNERAL DIRECTOR Robert L. Snowden
ADDRESS Hedgesville Md

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring — LENGTH OF STAY (In this place) 15 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10107 Pierce Dr

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Monty
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
STREET ADDRESS (If rural, give location) 10107 Pierce Dr

3. NAME OF DECEASED (Type or Print): (First) Harry (Middle) Irving (Last) Bryant
4. DATE OF DEATH: (Month) Jan. (Day) 25 (Year) 1953
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 12/19/92
9. AGE last birthday: 60 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurseryman
10b. KIND OF BUSINESS OR INDUSTRY: Own business
11. BIRTHPLACE (State or foreign country): Cortland, Virginia
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: Alfred Ashton Bryant
14. MOTHER'S MAIDEN NAME: Zeaulene Mayfield Williams
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT AND ADDRESS: Mrs. Mabel G. Bryant, 10,107 Pierce Drive Silver Spring, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary occlusion — ½ hr.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Pernicious patient 1 mo. 2 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

Frank J. Brostaut M.D — Washington D.C. — 1-25-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF 1/28/53 — NAME OF CEMETERY OR CREMATORY: St. Mark's Episcopal Church Cemetery — LOCATION (City, town, or county) (State): Fairland, Montgomery Co., Md.

DATE REC'D BY LOCAL REG. 1/27/53 — REGISTRAR'S SIGNATURE — 24. FUNERAL DIRECTOR: Clarence Humphreys — ADDRESS: 8434 Georgia Ave. Silver Spring, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 3-4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
LENGTH OF STAY (in this place) 3 weeks
HOSPITAL OR INSTITUTION OR STREET ADDRESS Maple Lane Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
STREET ADDRESS (If rural give location) 8003 Eastern Ave.

3. NAME OF DECEASED (Type or Print): (First) SARAH (Middle) Emma (Last) CAMPBELL
4. DATE OF DEATH: (Month) 1 (Day) 20 (Year) 1953
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: 7/28/66
9. AGE last birthday: 86 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Saleslady
10b. KIND OF BUSINESS OR INDUSTRY: Dry Goods
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Joseph Little
14. MOTHER'S MAIDEN NAME: Sarah Galloway
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs. Harry E. Lohmeyer, 8003 Eastern Ave. Silver Spring, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) CARCINOMA OF BREAST

170X

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) GENERALIZED CARCINOMATOSIS

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. SENILITY

19a. DATE OF OPERATION: NONE
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): NONE
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) NONE m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 18, 1952, to JAN 20, 1953, that I last saw the deceased alive on JAN 20, 1953, and that death occurred at 3:45 p.m., from the causes and on the date stated above.

SIGNATURE Henry Lohmeyer (Degree or title) M.D. ADDRESS 1603 19th St. N.W. Washington, D.C. DATE SIGNED 1/20/53

23. BURIAL, CREMATION REMOVAL (Specify) Burial; DATE THEREOF 1/23/53; NAME OF CEMETERY OR CREMATORY Glenwood Cemetery; LOCATION (City, town, or county) (State) Washington, D. C.

DATE REC'D BY LOCAL REG. 1/23/53; REGISTRAR'S SIGNATURE Frances Patterson

24. FUNERAL DIRECTOR Turner L. Sunshine; ADDRESS 8434 Georgia Ave. Silver Spring, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physi[illegible]: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chevy Chase,
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5612 Western Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE; COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) AUSTIN (Middle) FRANCIS (Last) CANFIELD

4. DATE OF DEATH: (Month) January (Day) 16, (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Dec. 23, 1894

9. AGE last birthday: 58 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lawyer

10b. KIND OF BUSINESS OR INDUSTRY: Lawyer

11. BIRTHPLACE (State or foreign country): Mahonoy City, Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John T. Canfield

14. MOTHER'S MAIDEN NAME: Mary Maley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): World War I

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Austin F. Canfield, Jr., 5612 Western Ave.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Coronary Occlusion

Antecedent cause (6) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic Heart Disease (c) Pneumonia attacks in May & September 1952

INTERVAL BETWEEN ONSET AND DEATH: 30 min. at least 2 years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify): None -

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/1/52 19..... to 1/16..... 1953 that I last saw the deceased alive on 1/16/53 19..... and that death occurred at 1:20 a.m., from the causes and on the date stated above.

SIGNATURE William Tilley MD (Degree or title) ADDRESS 1150 Conn Ave Wash DC DATE SIGNED 1/16/53

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: Jan. 19, 1953

NAME OF CEMETERY OR CREMATORY: Ft. Lincoln

LOCATION (City, town, or county) (State): Prince Georges County, Maryland

DATE REC'D BY LOCAL REG. 1/19/53

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR ADDRESS: Joseph Gawler Sons 1756 Penn Ave NW.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
LENGTH OF STAY (in this place) 20 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
STREET ADDRESS (If rural give location) 5819 Wingate Drive

3. NAME OF DECEASED: (Type or Print) (First) Hannah (Middle) Louise (Last) Cavin

4. DATE OF DEATH: (Month) Jan. (Day) 6 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: June 3 1873

9. AGE last birthday: 79 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Massachusetts

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Paul Hiltz

14. MOTHER'S MAIDEN NAME: Catherine Ford

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: James P. Cavin- 5819 Wingate Drive, Bethesda, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between Onset And Death

331X

Immediate cause (a) Cerebral Hemorrhage

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) Arteriosclerosis generalized

DUE TO (c) Cardiac & Cerebral Manifestations

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 1, 1952, to Jan. 6, 1953 that I last saw the deceased alive on Jan. 6, 1953, and that death occurred at 10:15 p.m., from the causes and on the date stated above.

SIGNATURE [signature] (Degree or title) ADDRESS DATE SIGNED 1-7-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit

DATE THEREOF 1-8-53

NAME OF CEMETERY OR CREMATORY Beechbrook Cemetery

LOCATION (City, town, or county) Essex Co., (State) Mass.

DATE REC'D BY LOCAL REGISTRAR 1/9/53

REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR Robert E. Humphrey ADDRESS Bethesda, Md.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY MONTGOMERY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
LENGTH OF STAY (in this place) 4 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Four Glenn Villa

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE TAKOMA PARK COUNTY MONTGOMERY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN TAKOMA PARK, MD.
STREET ADDRESS (If rural, give location) 615 Boston Ave. Takoma Pk.

3. NAME OF DECEASED (Type or Print) (First) NELLIE (Middle) CAFFREY (Last) CHANDLER.

4. DATE OF DEATH (Month) JANUARY (Day) 8 (Year) 1953

5. SEX F | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed | 8. DATE OF BIRTH 3/14/67 | 9. AGE last birthday 84 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY None. | 11. BIRTHPLACE (State or foreign country) Canada. | 12. CITIZEN OF WHAT COUNTRY? Canada.

13. FATHER'S NAME Wm. Rogers | 14. MOTHER'S MAIDEN NAME Adaline Rogers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS Sarah D. Conant – daughter.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pneumonia, Bilateral — Interval between onset and death: 2 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Infectious disorder — 10 days

571.1

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis — Yrs

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/1, 1953 to 1/8, 1953, that I last saw the deceased alive on 1/8, 1953, and that death occurred at 11:30 a.m., from the causes and on the date stated above.

SIGNATURE: Seymour Greenbaum (Degree or title) M.D. ADDRESS 9300 Fenning Dr Bethesda Md. DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF 1/11/53 | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. 1/12/53 | REGISTRAR'S SIGNATURE Frances Lee | 24. FUNERAL DIRECTOR W. B. Chapman & Co. | ADDRESS

Insert G152 - Item #14
1/14/53 mmb

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 [illegible]

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH:**
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda
LENGTH OF STAY (in this place): 1½
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Suburban

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Chevy Chase
STREET ADDRESS (If rural give location): 6802 Meadow Lane

**3. NAME OF DECEASED: (Type or Print)** (First) Helen (Middle) Adele (Last) Clapp.

**4. DATE OF DEATH:** (Month) Jan (Day) 5. (Year) 1953

**5. SEX:** F

**6. COLOR OR RACE:** W

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):** Married

**8. DATE OF BIRTH:** Jan 1, 1880

**9. AGE last birthday:** 73 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY:**

**11. BIRTHPLACE** (State or foreign country): New York

**12. CITIZEN OF WHAT COUNTRY?** USA

**13. FATHER'S NAME:** Richard M. Roberts

**14. MOTHER'S MAIDEN NAME:** Isabella Stewart

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.): No — (If Yes, give war or dates of service)

**16. SOCIAL SECURITY No.:**

**17. INFORMANT & ADDRESS:** Clark H. Clapp 6802 Meadow Lane Chevy Chase Md

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause — (a) Ponto-Mesencephalic Stroke — DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. — (b) Cardio-vascular renal disease 2 yrs — DUE TO

(c)

Interval Between Onset And Death: 24 hrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:**

**19b. MAJOR FINDINGS OF OPERATION**

**20. AUTOPSY?** Yes ☐ No ☐

**21.** ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 4, 1953, to Jan. 5, 1953, that I last saw the deceased alive on Jan 5, 1953, and that death occurred at 4:55 P.M., from the causes and on the date stated above.

SIGNATURE: Sidney Bloomaro (Degree or title) M.D. — ADDRESS: 3921 Longmeadow St NW Washington D.C. — DATE SIGNED: 1/6/53

**23.** BURIAL, CREMATION, REMOVAL (Specify) — DATE THEREOF: Jan 7 1953 — NAME OF CEMETERY OR CREMATORY: Bethel Hill Cem — LOCATION (City, town, or county) (State): Hamilton Va Md

DATE REC'D BY LOCAL REGISTRAR: 1/7/53 — REGISTRAR'S SIGNATURE

**24. FUNERAL DIRECTOR** — ADDRESS: Chevy Chase Funeral Home 5103 Wisconsin Ave N.W. Washington D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 215

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY: Montgomery — MARYLAND
CITY OR TOWN (If outside corporate limits, write and give nearest town): Bethesda, Rural — RURAL — LENGTH OF STAY (in this place): 3 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U. S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Pennsylvania — COUNTY: Delaware
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Drexel Hill
STREET ADDRESS (If rural give location): 20 Valley Road

3. NAME OF DECEASED: (First) Marie (Middle) Callaghan (Last) CONE

4. DATE OF DEATH: (Month) January (Day) 25 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Jan. 29, 1900

9. AGE last birthday: 52 yrs. — IF UNDER 1 YEAR: Months 11, Days 27 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: - - - - - - - -

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Patrick CALLAGHAN

14. MOTHER'S MAIDEN NAME: Rosalie SNELSIRE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Unk — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: - - - - - - - -

17. INFORMANT & ADDRESS: Husband: William Wheatly CONE, same as item 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset And Death |
|---|---|---|
| 170X Immediate cause | (a) Metastatic squamous carcinoma to brain | 1 month |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. | DUE TO (b) Squamous carcinoma, left breast | 11 years. |
| | DUE TO (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 22, 1953, to Jan 25, 1953, that I last saw the deceased alive on Jan 25, 1953, and that death occurred at 6:33 P.M., from the causes and on the date stated above.

SIGNATURE: E. P. Phelan
(Degree or title): E. P. THELAN, LCDR, MC, USN
ADDRESS: U. S. Naval Hospital, Bethesda, Maryland
DATE SIGNED: Jan 26, 1953

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Jan 28, 1953
NAME OF CEMETERY OR CREMATORY: U. S. Naval Academy
LOCATION (City, town, or county): Annapolis
(State): Maryland

DATE REC'D BY LOCAL REGISTRAR: January 26, 1953
REGISTRAR'S SIGNATURE: Elsie Whittington

24. FUNERAL DIRECTOR: R. ELLIS CLARK, EASTON, MARYLAND
ADDRESS

RECEIVED
JAN 27 1953
BUREAU V

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural
LENGTH OF STAY (in this place): MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Gaithersburg

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural
STREET ADDRESS (If rural, give location): Gaithersburg

3. NAME OF DECEASED (Type or Print): (First) Theodore (Middle) R. (Last) Crawford

4. DATE OF DEATH: (Month) Jan. (Day) 25 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: 4-23-1900

9. AGE last birthday: 52 yrs. If under 1 year: Months 11 Days 2 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mgr. Elect. Appliance

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Emory Crawford

14. MOTHER'S MAIDEN NAME: Mariam Lehman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT AND ADDRESS: Lillian M. Crawford - Wife #2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Coronary Thrombosis | 10 days |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Coronary Sclerosis | 5 yrs |
| | (c) | |

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 18 Jan., 1953, to 25 Jan., 1953, that I last saw the deceased alive on 25 Jan., 1953, and that death occurred at 11 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): W S Murphy MD

ADDRESS: Rockville Md

DATE SIGNED: 28 Jan 53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Jan. 28, 1953

NAME OF CEMETERY OR CREMATORY: Forest Oak

LOCATION (City, town, or county) (State): Gaithersburg Maryland

DATE REC'D BY LOCAL REG.: JAN 28 1953

REGISTRAR'S SIGNATURE: Ursula Hooke

24. FUNERAL DIRECTOR: Robert H. Crumpley

ADDRESS: Bethesda, Md.

Filed 6:00 - Item #14
Vital Stat. mnt.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH:**
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda
LENGTH OF STAY (in this place): 12 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Suburban

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE: Maryland — COUNTY: Mont.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rockville
STREET ADDRESS (If rural give location): RFD #2 Seven Locks Road

**3. NAME OF DECEASED:** (Type or Print) (First) Elsie (Middle) Virginia (Last) Cross

**4. DATE OF DEATH:** (Month) Jan 1 (Day) (Year) 1953

**5. SEX:** female

**6. COLOR OR RACE:** Negro

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):** Married

**8. DATE OF BIRTH:** April 23 1927

**9. AGE last birthday:** 25 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

**10a. USUAL OCCUPATION.** Give kind of work done during most of working life, even if retired): Domestic

**10b. KIND OF BUSINESS OR INDUSTRY:**

**11. BIRTHPLACE** (State or foreign country): Maryland.

**12. CITIZEN OF WHAT COUNTRY?** USA

**13. FATHER'S NAME:** George Harvey Twyman

**14. MOTHER'S MAIDEN NAME:** Emma Thomas

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) No — (If Yes, give war or dates of service)

**16. SOCIAL SECURITY NO.:**

**17. INFORMANT & ADDRESS:** William G. Cross RFD #2 Seven Locks Road Rockville, Md.

**18. MEDICAL CERTIFICATION**

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

204 Immediate cause (a) Pneumonia — 14 days

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Leukemia, acute (myeloguenous — 4 mos

DUE TO (c)

11 OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death. None

**19a. DATE OF OPERATION:** — **19b. MAJOR FINDINGS OF OPERATION** — **20. AUTOPSY?** Yes ☐ No ☒

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 21, 1952, to Jan. 1, 1953, that I last saw the deceased alive on Dec. 31, 1952, and that death occurred at 6.25 P.M. from the causes and on the date stated above.

SIGNATURE (Degree or title): Robert J. Lewis (M.D.) — ADDRESS: 5029 Bethesda Ave Bethesda, Md. — DATE SIGNED: 1/1/53

**23. BURIAL, CREMATION, REMOVAL** (Specify): Burial — DATE THEREOF: Jan 5, 1953 — NAME OF CEMETERY OR CREMATORY: Forest Park — LOCATION (City, town, or county) (State): Md Rockville Md

DATE REC'D BY LOCAL REGISTRAR: 1/5/53 — REGISTRAR'S SIGNATURE:

**24. FUNERAL DIRECTOR:** Robert L. Snouffer — ADDRESS: Rockville

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 00644 423

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY MONTGOMERY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN TAKOMA PARK
LENGTH OF STAY (in this place) 16 YRS.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 103 GRANT AVE

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY MONTG.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN TAKOMA PARK
STREET ADDRESS (If rural give location) 103 GRANT AVE.,

3. NAME OF DECEASED: (Type or Print) (First) THOMAS (Middle) B. (Last) CROXTON

4. DATE OF DEATH: (Month) JAN. (Day) 5 (Year) 1953.

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: APRIL 1861

9. AGE last birthday: 91 yrs. IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —

10a. USUAL OCCUPATION Give kind of work done during most of working life, (even if retired): REP. FARMER

10b. KIND OF BUSINESS OR INDUSTRY: GENERAL FARMING

11. BIRTHPLACE (State or foreign country): DUNNSVILLE, ESSEX CO., VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: CLAIBOURNE CROXTON

14. MOTHER'S MAIDEN NAME: SUSAN DUNN.

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) — (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: MRS. RUSSELL BOHN, 1036 GRANT AVE., TAKOMA PARK, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) DUE TO Arteriosclerotic Heart Disease with Auricular Fibrillation

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO Generalized Arteriosclerosis

(c)

4320

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. ,1949, to JAN 5 , 1953, that I last saw the deceased alive on 12/24, 1952, and that death occurred at 2:20 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Dean H. Harding M.D. — ADDRESS 113 Carroll St NW Wash DC — DATE SIGNED 1-5-53

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL — DATE THEREOF JAN. 7 1953 — NAME OF CEMETERY OR CREMATORY EPHESUS BAPTIST CHURCH CEM. — LOCATION (City, town, or county) (State) DUNNSVILLE, ESSEX CO., VIRGINIA.

DATE REC'D BY LOCAL REGISTRAR JAN 5 1953 — REGISTRAR'S SIGNATURE — 24. FUNERAL DIRECTOR — ADDRESS Gardner Gallery, 254 CARROLL ST. N.W. TAKOMA PARK 12, D.C.

(over)

VS. A15

This Certificate approved by
Dr Frank J Broschart. Dep. Medical Examiner.
Montgomery Co. PA
Dean Harding M.D.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH:**
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda — RURAL
LENGTH OF STAY (in this place): 14 yrs 7 mos 35 min
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Suburban Hospital 8600 Old Georgetown Rd.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Springs
STREET ADDRESS (If rural give location): 8003 Easton Dr.

**3. NAME OF DECEASED:** (Type or Print) (First) Ada (Middle) Claire (Last) Cummins

**4. DATE OF DEATH:** (Month) 1 (Day) 4 (Year) 1953

**5. SEX:** Female

**6. COLOR OR RACE:** White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED** (Specify): Divorced

**8. DATE OF BIRTH:** Aug 10 1900

**9. AGE last birthday:** 52 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY:**

**11. BIRTHPLACE** (State or foreign country): Paw Paw Virginia

**12. CITIZEN OF WHAT COUNTRY?** U.S.A.

**13. FATHER'S NAME:** James Robertson

**14. MOTHER'S MAIDEN NAME:** Lillian Middleton

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no or unk.) (If Yes, give war or dates of service)

**16. SOCIAL SECURITY NO.:**

**17. INFORMANT & ADDRESS:** Buston E. Cummins Jr.

**18. MEDICAL CERTIFICATION**

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

153X

Immediate cause (a) Pulmonary Infarct Left and Cardiac Failure — Interval Between Onset And Death: 24 hrs.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) DUE TO Partial Intestinal obstruction — 24 hrs.
(c) DUE TO Carcinoma of Sigmoid — 3 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:**

**19b. MAJOR FINDINGS OF OPERATION**

**20. AUTOPSY?** Yes ☒ No ☐

**21.** ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 1952, to Jan 4, 1953, that I last saw the deceased alive on Jan 4., 1953 and that death occurred at 3:35 AM from the causes and on the date stated above.

SIGNATURE (Degree or title): Frank A Zack M.D. — ADDRESS: 2248 Gallery Silver Spring Md — DATE SIGNED: Jan 4, 1953

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 1/6/53 — NAME OF CEMETERY OR CREMATORY: Ft. Lincoln — LOCATION (City, town, or county) (State): Prince George Co. Md.

DATE REC'D BY LOCAL REGISTRAR: 1/5/53 — REGISTRAR'S SIGNATURE: Lisle M. Thompson

24. FUNERAL DIRECTOR: Warner E. Pumphrey Inc. — ADDRESS: Silver Spring, Md.

RECEIVED
JAN 7
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda; LENGTH OF STAY (in this place) 7mo 4da; HOSPITAL OR INSTITUTION OR STREET ADDRESS 9200 Old Georgetown Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE; COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington, D.C.; STREET ADDRESS (If rural, give location) 3031 Oliver St. N.W. ✓

3. NAME OF DECEASED (Type or Print): (First) Lula (Middle) Ida (Last) Curley

4. DATE OF DEATH: (Month) Jan (Day) 26 (Year) 1953

5. SEX: F

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: June 15, 1865

9. AGE last birthday: 87 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dress-Fitter

10b. KIND OF BUSINESS OR INDUSTRY: Woolen and Clothing

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: unk.

14. MOTHER'S MAIDEN NAME: unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no.

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Mrs. G.A. Cummer 3031 Oliver St. N.W. Washington D.C.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Thrombosis — Interval Between Onset and Death: 2 weeks

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 21, 1952, to Jan. 26, 1953, that I last saw the deceased alive on Jan. 24, 1953, and that death occurred at 12.05 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Rufus Trowell, M.D. ADDRESS: 5516 Nebraska Ave. DATE SIGNED: 1/26/53

23. BURIAL, CREMATION REMOVAL (Specify): Buried | DATE THEREOF: 1-28-53 | NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem. | LOCATION (City, town, or county) (State): Prince Georges Co. Md.

DATE REC'D BY LOCAL REG.: 2/6/53 | REGISTRAR'S SIGNATURE:

24. FUNERAL DIRECTOR: A.H. Hines & Co. ADDRESS: Washington D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: MONTGOMERY — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA (Rural)
LENGTH OF STAY (in this place): 3 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U. S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: WISCONSIN — COUNTY: CLAIRE
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EAU CLAIRE
STREET ADDRESS (If rural give location): 2901 Eddy Lane

3. NAME OF DECEASED (Type or Print): (First) VERNON (Middle) EDWARD (Last) CURREN

4. DATE OF DEATH: (Month) January (Day) 20, (Year) 19 53

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: July 24, 1872

9. AGE last birthday: 80 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): SALESMAN

10b. KIND OF BUSINESS OR INDUSTRY: - - - - - - - - -

11. BIRTHPLACE (State or foreign country): Chippewa Falls, WISCONSIN

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Benjamin CURREN

14. MOTHER'S MAIDEN NAME: Martha VAUGHN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): NO — (If Yes, give war or dates of service): - - - - -

16. SOCIAL SECURITY NO.: 390-01-3363

17. INFORMANT & ADDRESS: Son: Ralph Benjamin CURREN, 2100 Massachusetts Ave., Washington, D.C.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset And Death |
|---|---|---|
| Immediate cause | (a) Myocardial Infarction | 2 days |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. | (b) DUE TO Coronary Thrombosis | 2 days |
| | (c) DUE TO Arterio-Sclerotic Heart Disease | 8-10 yrs. |

U.C.D.

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes X No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-17-, 19 53, to 1-20-, 19 53, that I last saw the deceased alive on 1-20-, 19 53, and that death occurred at 10:30 AM, from the causes and on the date stated above.

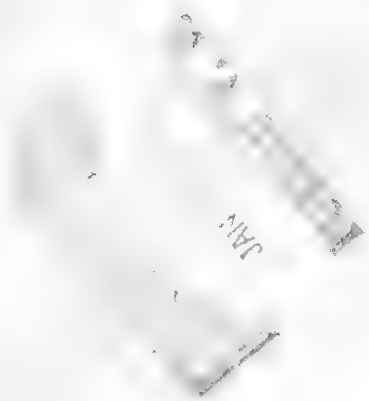
SIGNATURE (Degree or title): William Thomas Hall M.D. — ADDRESS: U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 1-20-

23. BURIAL, CREMATION, REMOVAL (Specify): Removal — DATE THEREOF: 1-21-53 — NAME OF CEMETERY OR CREMATORY: EAU CLAIRE — LOCATION (City, town, or county) (State): EAU CLAIRE WISCONSIN

DATE REC'D BY LOCAL REGISTRAR: 1-20-53 — REGISTRAR'S SIGNATURE: Edith Whittington

24. FUNERAL DIRECTOR: R. A. PUMPHREY — ADDRESS: 7557 Wisconsin Ave., Bethesda, Maryland

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. [illegible]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH:**

COUNTY [illegible] MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BETHESDA (RURAL)

LENGTH OF STAY (in this place) 24 Days

HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. NAVAL HOSPITAL

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

STATE MARYLAND COUNTY PRINCE GEORGES

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRANDYWINE

STREET ADDRESS (If rural give location) RFD #2, Box 190

**3. NAME OF DECEASED:** (Type or Print) (First) Walter (Middle) Howell (Last) CURTIS

**4. DATE OF DEATH:** (Month) January (Day) 4, (Year) 1953

| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR Months | Days | IF UND. 24 HRS. Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Divorced | 30 May 1905 | 47 yrs. | | | | |

| 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| (Mo) Petty Officer | U. S. Navy | Washington, D. C. | U. S. |

**13. FATHER'S NAME:** William CURTIS

**14. MOTHER'S MAIDEN NAME:** Sallie DALTON

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: | 17. INFORMANT & ADDRESS: |
|---|---|---|---|
| YES | WWII | UNKNOWN | Sister: Mrs. Myrtle MULLINS-Same as above |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset And Death |
|---|---|---|
| Immediate cause | (a) Liver Failure | 1 Mo |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. | (b) DUE TO Metastases from Adenocarcinoma of Stomach ? | |
| | (c) DUE TO | |

151+

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☒ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from 12-11, 19 52, to 1-4-, 19 53, that I last saw the deceased alive on 1-4-, 19 53, and that death occurred at 6:45 PM, from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| P. E. Adamson | Lt. (MC) USNR | U. S. Naval Hospital, Bethesda, Md. | 5 Jan. 53 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) | ADDRESS |
|---|---|---|---|---|
| [illegible] | 1-5-53 | Arlington National | Arlington Virginia | |

| DATE REC'D BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| JAN 5 1953 | Edith Whittington | CHAMBERS | 247 14th Street, SW, Washington, D. C. |

Hen. F. B150-1/14/53-mnh

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

BEGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY [illegible] MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN [illegible]
LENGTH OF STAY (in this place): [illegible] Da
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U. S. NAVAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE [illegible] COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: BRIDGE
STREET ADDRESS (If rural give location): Building 14, apt. ✓

3. NAME OF DECEASED (Type or Print): (First) EMMA (Middle) MILDRED (Last) DAVENPORT
4. DATE OF DEATH: (Month) Jan. (Day) 8 (Year) 19 5[illegible]
5. SEX: FEMALE
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 9-24-13
9. AGE last birthday: 39 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): UNKNOWN
10b. KIND OF BUSINESS OR INDUSTRY: UNKNOWN
11. BIRTHPLACE (State or foreign country): HONOLULU, HAWAII
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Daniel T. HOUGHTAILING
14. MOTHER'S MAIDEN NAME: Rose AWAAWA
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) UNKNOWN (If Yes, give war or dates of service) - - - - -
16. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT & ADDRESS: Husband: Braxton B. DAVENPORT - Same as above

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
170X
Immediate cause (a) Carcinoma left breast with metastases DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) DUE TO
(c)
Interval Between Onset And Death: 18 mo

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes X No

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour)
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-13-,1952, to 1-3-53, 19.., that I last saw the deceased alive on 1-3-, 19.., and that death occurred at 4:05 PM, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Lucretia Florence Edr (MC) USN USNH, NNMC, Bethesda, Md. 1-3-

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF 1-9-53 NAME OF CEMETERY OR CREMATORY Hopewood LOCATION (City, town, or county) Rising Sun (State) Maryland
DATE REC'D BY LOCAL REGISTRAR 1-
REGISTRAR'S SIGNATURE Cecil Whittington
24. FUNERAL DIRECTOR Ted Patterson & Son ADDRESS Perryville, Md.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington; LENGTH OF STAY (in this place) 12 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS Shaftsbury St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington, Md; STREET ADDRESS (If rural, give location) Shaftsbury St.

3. NAME OF DECEASED (Type or Print): (First) Elizabeth (Middle) (Last) Davis

4. DATE OF DEATH: (Month) January (Day) 22 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: March 12, 1867

9. AGE last birthday: 85 yrs. If under 1 year: Months / Days / Hours / Min. / If under 24 hrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Xavier Johnson

14. MOTHER'S MAIDEN NAME: Underwood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Malachi Williams (Son)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiorenal Disease

592 X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis

(c) Chronic Nephritis

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 19, 1952 to Jan 22, 1953, that I last saw the deceased alive on Jan 21, 1953, and that death occurred at 12:50 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Wesley Sewell M.D. ADDRESS Silver Spring DATE SIGNED 1-24-53

23. BURIAL, CREMATION OR REMOVAL (Specify) Burial; DATE 1/25/53; NAME OF CEMETERY OR CREMATORY Pilgrims Baptist; LOCATION (City, town, or county) Laytonsville (State) Md

DATE REC'D BY LOCAL REG. 1-26-53; REGISTRAR'S SIGNATURE Frances Talbot; 24. FUNERAL DIRECTOR Robert L. Snowden; ADDRESS Rockville Md

JAN 3 1953

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 217

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Olney; MARYLAND; LENGTH OF STAY (in this place) 2 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Montgomery County General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Damascus; STREET ADDRESS (If rural, give location) R.F.D. Monrovia

3. NAME OF DECEASED (Type or Print): (First) Dorsey (Middle) Waters (Last) Day

4. DATE OF DEATH: (Month) January (Day) 13 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Sept. 9, 1868

9. AGE last birthday: 84 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own farm

11. BIRTHPLACE (State or foreign country): Montgomery County, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James W. Day

14. MOTHER'S MAIDEN NAME: Sarah ? Day

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ----

17. INFORMANT AND ADDRESS: Joseph D Day, Monrovia, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Cerebral Thrombosis | 3 days |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Generalized arteriosclerosis | |
| | (c) Bronchopneumonia. | 2 days |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 1, 1951, to Jan. 13, 1953, that I last saw the deceased alive on Jan 13, 1953, and that death occurred at 2:10 p.m., from the causes and on the date stated above.

SIGNATURE: M. McKendree Bryan (Degree or title) M.D. ADDRESS: Damascus Md DATE SIGNED: 1/14/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: Jan. 15, 1953 | NAME OF CEMETERY OR CREMATORY: Bethesda Church | LOCATION (City, town, or county) (State): Browningsville, Md.

DATE REC'D BY LOCAL REG.: 1-14-53 | REGISTRAR'S SIGNATURE: Gertrude B Lawrie

24. FUNERAL DIRECTOR: Clin L. Molesworth, Damascus, Md ADDRESS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Springs | LENGTH OF STAY (in this place) 1 year
HOSPITAL OR INSTITUTION OR STREET ADDRESS Maple Lane Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE D.C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural give location) 3811 - Yuma St. N.W.

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) (Last) dePASCHALIS

4. DATE OF DEATH: (Month) JAN (Day) 19 (Year) 1953

5. SEX: Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed | 8. DATE OF BIRTH: March 11, 1874 | 9. AGE last birthday: 78 yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife | 10b. KIND OF BUSINESS OR INDUSTRY: Home | 11. BIRTHPLACE (State or foreign country): Ireland | 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George Anderson | 14. MOTHER'S MAIDEN NAME: O'Connor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If yes, give war or dates of service) None | 16. SOCIAL SECURITY NO. None | 17. INFORMANT: Mrs. Rose B dePaschalis

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) CORONARY THROMBOSIS

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) CHRONIC MYOCARDITIS

(c) RHEUMATOID ARTHRITIS

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. SENILITY

19a. DATE OF OPERATION: None | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) None | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) None m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from MAY 1, 1952, to JAN 19, 1953, that I last saw the deceased alive on JAN 19, 1953 and that death occurred at 7:40 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Kenyon Lowder M.D. | ADDRESS 1603 19th St. N.W. Washington, D.C. | DATE SIGNED 1/19/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF 1/23/53 | NAME OF CEMETERY OR CREMATORY Soldier's National Cemetery | LOCATION (City, town, or county) Washington DC (State)

DATE REC'D BY LOCAL REG. 1-19-53 | REGISTRAR'S SIGNATURE Frances Potter | 24. FUNERAL DIRECTOR James T. Ryan Inc. | ADDRESS 317 Penna. Ave. S.E.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A1

1. PLACE OF DEATH:
COUNTY [illegible] MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: BETHESDA (RURAL)
LENGTH OF STAY (in this place): 6-1/2 Hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S. NAVAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE [illegible] COUNTY [illegible]
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
STREET ADDRESS (If rural give location): [illegible] GREELEY AVENUE

3. NAME OF DECEASED (Type or Print): (First) Raymond (Middle) Henry (Last) DICK

4. DATE OF DEATH: (Month) January (Day) 5, (Year) 1953

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: 5 March 1902

9. AGE last birthday: 51 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Officer

10b. KIND OF BUSINESS OR INDUSTRY: U. S. Navy

11. BIRTHPLACE (State or foreign country): OHIO

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Henry DICK

14. MOTHER'S MAIDEN NAME: Judith HANSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): YES (If Yes, give war or dates of service): WWII

16. SOCIAL SECURITY NO.: UNKNOWN

17. INFORMANT & ADDRESS: wife: Joan Louise DICK - Same as above

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

Immediate cause (a) Coronary Occlusion — Interval Between Onset And Death: 1/2 hr.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — 10+ months
DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-5-53, to 1-5-53, that I last saw the deceased alive on 1-5-53, and that death occurred at 10:30 PM, from the causes and on the date stated above.

SIGNATURE (Degree or title): Warren Clarke MD LTJG
ADDRESS: USNH Bethesda
DATE SIGNED: 1-6-53

23. BURIAL, CREMATION, REMOVAL (Specify)
DATE THEREOF
NAME OF CEMETERY OR CREMATORY
LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REGISTRAR: 1-5-53
REGISTRAR'S SIGNATURE: Eliot Worthington

24. FUNERAL DIRECTOR: Robert A. Pumphrey
ADDRESS: [illegible] Bethesda, Maryland

RECEIVED
JAN
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 223

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND; CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Silver Spring; LENGTH OF STAY (in this place) 2 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Sanitarium & Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington; STREET ADDRESS (If rural give location) 5225 Conn. Ave. N.W. ✓

3. NAME OF DECEASED: (Type or Print) (First) Ruth (Middle) Estelle (Last) Hall

4. DATE OF DEATH: (Month) Jan (Day) 7 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 1-17-18

9. AGE last birthday: 34 yrs. If UNDER 1 YEAR: Months, Days; If UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry Monroe Hewitt

14. MOTHER'S MAIDEN NAME: Pinkett Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Medical Records Washington Sanitarium & Hospital

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion — Interval Between Onset And Death: Terminal

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Hypertension — Interval Between Onset And Death: years

DUE TO

(c)

42.1

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1953, to Jan 7, 1953, that I last saw the deceased alive on Jan 6, 1953, and that death occurred at 5:30 A.M., from the causes and on the date stated above.

SIGNATURE Robert Abare (Degree or title) MD ADDRESS Takoma Park Md. DATE SIGNED 1/7/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Jan 9 1953 NAME OF CEMETERY OR CREMATORY — LOCATION (City, town, or county) Montgomery (State) Md

DATE REC'D BY LOCAL REGISTRAR Jan 8-1953 REGISTRAR'S SIGNATURE J. Wilson Dodd

24. FUNERAL DIRECTOR W W Deal ADDRESS 4812 Ga Ave Wash DC

VS. A15

RECEIVED

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 217

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town): Olney
LENGTH OF STAY (in this place): 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: The Montgomery County General Hospital, Inc.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE: Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ellicott City
STREET ADDRESS (If rural give location):

**3. NAME OF DECEASED:** (Type or Print) (First) George (Middle) W (Last) Dorsey

**4. DATE OF DEATH:** (Month) January (Day) 30 (Year) 1953

**5. SEX:** Male

**6. COLOR OR RACE:** Colored

**7. SINGLE, MARRIED, WIDOWED, DIVORCED** (Specify): Divorced

**8. DATE OF BIRTH:** ? 1880

**9. AGE** Last birthday: 72 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** Give kind of work done during most of working life, even if retired): Laborer

**10b. KIND OF BUSINESS OR INDUSTRY:** Construction

**11. BIRTHPLACE** (State or foreign country): Howard County Md

**12. CITIZEN OF WHAT COUNTRY?** U.S.A.

**13. FATHER'S NAME:** Charles Dorsey

**14. MOTHER'S MAIDEN NAME:** Sarah Coates

**15. WAS DECEASED EVER IN U.S ARMED FORCES?** (Yes, no, or unk.) no (If Yes, give war or dates of service) no

**16. SOCIAL SECURITY NO.:** 213-12-0194

**17. INFORMANT & ADDRESS:** Hospital Records

**18. MEDICAL CERTIFICATION**

**I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH**

610 X

Immediate cause (a) Uraemia — Interval Between Onset And Death: 3 days

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Urinary Retention — 10 days
DUE TO (c) Prostatic Hypertrophy — 2

**11. OTHER SIGNIFICANT CONDITIONS** Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:** —

**19b. MAJOR FINDINGS OF OPERATION** None

**20. AUTOPSY?** Yes ☐ No ☐

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/24/ , 1953, to 1/30/ , 1953, that I last saw the deceased alive on 1/29/ , 1953, and that death occurred at 6:40 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) M.D. — ADDRESS Sandy Spring — DATE SIGNED 1/30/53

**23. BURIAL, CREMATION, REMOVAL** (Specify): Burial — DATE THEREOF 2.2.1953 — NAME OF CEMETERY OR CREMATORY: Locust Chapel — LOCATION (City, town, or county) Atholton (State) Md

DATE REC'D BY LOCAL REGISTRAR: 1-30-53 — REGISTRAR'S SIGNATURE: Gertrude B Lawler

**24. FUNERAL DIRECTOR:** F.C. Hagenbuchen — ADDRESS: Ellicott City Md

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 51

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND; CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Takoma Park; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 6821 Eastern Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Montg.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park; STREET ADDRESS (If rural, give location) 6821 Eastern Ave.

3. NAME OF DECEASED: (Type or Print) (First) LILLIE (Middle) HOPKINS (Last) DOUGLAS

4. DATE OF DEATH: (Month) Jan. (Day) 12 (Year) 1953.

5. SEX: F

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: Sept 18. 1882

9. AGE last birthday: 70 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Frank Davis

14. MOTHER'S MAIDEN NAME: Sallie F. Brightwell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No

(If Yes, give war or dates of service) No.

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: Willard R. Douglas, 6821 Eastern Ave.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

331X

Immediate cause (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 Days

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Malignant Hypertension — 10 years

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 1 1946, to 12 Jan. 1953, that I last saw the deceased alive on 10 Jan., 1953, and that death occurred at 3 00 A m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

M. Rucker M.D. 7112 Willow Ave Takoma Park, Md. 12 Jan. 53

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF 1/14/53

NAME OF CEMETERY OR CREMATORY Glenwood Cem

LOCATION (City, town, or county) (State) Washington, D. C.

DATE REC'D BY LOCAL REG. Jan. 14 1953

REGISTRAR'S SIGNATURE J. Milton Nevill

24. FUNERAL DIRECTOR The L. H. Hines Co. ADDRESS Wash. D. C.

Item 18 Film G150 2-4-53 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
LENGTH OF STAY (in this place) 7
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville
STREET ADDRESS (If rural give location) 1102 Broadwood Drive

3. NAME OF DECEASED: (Type or Print) (First) William (Middle) Joseph (Last) Dunegin

4. DATE OF DEATH: (Month) Jan (Day) 19 (Year) 1953

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: Dec 27. 1924

9. AGE Last birthday: 28 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Accountant

10b. KIND OF BUSINESS OR INDUSTRY: Government

11. BIRTHPLACE (State or foreign country): Mississippi

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Allen Dunegin

14. MOTHER'S MAIDEN NAME: Hattie Jean Thomas

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 428-28-9660

17. INFORMANT & ADDRESS: Myrtle Alline Dunegin 1102 Broadwood Drive Rockville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocardial failure — DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) mitral stenosis & insufficiency — DUE TO
(c) Rheumatic fever - Inactive

Interval Between Onset And Death: 6 days

11 OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/20, 19 52, to 1/19, 19 53, that I last saw the deceased alive on 1/19, 1953, and that death occurred at 10.40 P.M. 1/19/53, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Alfred S. Norton M.D. 4711 Highland Ave Bethesda md. 1/19/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 1/23/53 — NAME OF CEMETERY OR CREMATORY Parklawn Cem. — LOCATION (City, town, or county) Rockville, (State) Md

DATE REC'D BY LOCAL REGISTRAR 1/21/53 — REGISTRAR'S SIGNATURE Consent to [illegible]

24. FUNERAL DIRECTOR ADDRESS The S.H. Hines Co. 2901 14th St NW Washington D.C.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 223

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 351

**1. PLACE OF DEATH:**
COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Takoma Park
LENGTH OF STAY (in this place) 23 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Sanitarium & Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
STREET ADDRESS (If rural, give location) 1000 Prospect Ave.

**3. NAME OF DECEASED:** (Type or Print) (First) Mrs. (Middle) Pearl Edith (Last) Eastman

**4. DATE OF DEATH:** (Month) 1 (Day) 2 (Year) 1953

| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Caucasian | Married | 3-1-76 | 66 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| HOUSEWIFE | OWN HOME | Rosalia Kansas | U.S.A. |

13. FATHER'S NAME: Sylvester King

14. MOTHER'S MAIDEN NAME: Ellis Elizabeth Bowyer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No. (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Hospital Records

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

1707

Immediate cause (a) Carcinomatosis — Interval between onset and death: 2 yrs

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Carcinoma of left breast

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION: | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 1, 19 52, to Jan 2, 19 53, that I last saw the deceased alive on Jan 2, 19 53, and that death occurred at 11:20 P. m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

Wilfred W Eastman M.D. 1200 Prospect Ave. Takoma Park Md Jan 2 1953

| 23. BURIAL, CREMATION REMOVAL (Specify): | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Jan 5, 1953 | George Washington Cem. | Riggs Rd. Pr Geo Co Md |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Jan 2 1953 | J. Holma Dodd | H. Arthur Walters | 254 Carroll St NW Takoma Park, D.C. |

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 2-14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY MONTGOMERY MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SILVER SPRING; LENGTH OF STAY (in this place) 22 YEARS; HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY MONTGOMERY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SILVER SPRING; STREET ADDRESS (If rural, give location) 10001 - KINROSS AVE

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| SAMUEL | | EAVES | 1 - | 9 - | 1953 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| MALE | WHITE | MARRIED | NOV-18-1873 | 79 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| MERCHANT | WHOLESALE GROCER | INDIANAPOLIS - INDIANA | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| SAMUEL EAVES | LOUISE ISAACS |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY No. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| NONE NONE | NONE | IDA M EAVES 10001 KINROSS AVE SIL SP MD |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Arteriosclerotic Heart Disease | — |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Generalized arteriosclerosis | — |
| | (c) Senility | — |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from 2/20/52, 19..., to 1/9/53, 19..., that I last saw the deceased alive on Jan 8, 1953, and that death occurred at 7 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Marion Bankhead M.D. ADDRESS 9541 Columbia Blvd. Silver Spring Md. DATE SIGNED 1/9/53

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 1-10-53 | Washington Natl. Cem. | FRANKLIN INDIANA |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 1-10-53 | Frances Gitter | W. C. Chamber Co | 1400 Chapin St WASH. D.C. |

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 223

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
LENGTH OF STAY (In this place) 8 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Sanitarium + Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Washington D.C., COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN —
STREET ADDRESS (If rural, give location) 1647 Fuller Street ✓

3. NAME OF DECEASED (Type or Print): (First) (Min) (Middle) Jean Cecile (Last) Endres
4. DATE OF DEATH: (Month) 1 (Day) 13 (Year) 1953
5. SEX: Female
6. COLOR OR RACE: Caucasian
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: 9-11-11
9. AGE last birthday: 41 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Washington D.C.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Joseph Endres
14. MOTHER'S MAIDEN NAME: Adele Muir
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Acute hepatitis | 8 days |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Anorexia | 8 days |
| | (c) Carbon tetrachloride poisoning | 12 days |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | |

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY home
(CITY OR TOWN) Washington (COUNTY) (STATE) D.C.
TIME OF INJURY (Month) 1 (Day) 1 (Year) 53 (Hour) 2 A.m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Taken carbon tetrachloride by mistake

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: Frank J. Boorhout (Degree or title) M.D. ADDRESS: Gaithersburg Md. DATE SIGNED: 1-13-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 1-16-53
NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
LOCATION (City, town, or county): Washington D.C. (State)
DATE REC'D BY LOCAL REG.: JAN-13 1953
REGISTRAR'S SIGNATURE: [illegible]
24. FUNERAL DIRECTOR: The S.H. Hines Co.
ADDRESS: 2901-14 St. N.W. Washington D.C.

JAN 15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda; LENGTH OF STAY (in this place) 33 Minutes; HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville; STREET ADDRESS (If rural, give location) Route 28

3. NAME OF DECEASED (Type or Print): (First) WAICO (Middle) EDWARD (Last) FLANARY

4. DATE OF DEATH: (Month) Jan (Day) 8 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: May 10, 1925

9. AGE last birthday: 27 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): (would) was not employed

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Walker Flannery

14. MOTHER'S MAIDEN NAME: Annie Kirk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Walker Flannery- Rt #28 Rockville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Septicemia ? possible brain abcess | 72- |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Diabetic acidosis | 96 hrs |
| 26 ? | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Nasal furunculosis

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: —

(CITY OR TOWN) (COUNTY) (STATE): — —

TIME OF INJURY (Month) (Day) (Year) (Hour): — — — — m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 6, 1953, to Jan 6, 1953 that I last saw the deceased alive on Jan 6, 1953, and that death occurred at 10:30 P.M. Jan 8, from the causes and on the date stated above.

SIGNATURE: John F. Stapleton (Degree or title) ADDRESS 326 E. Montgomery Ave Rockville, Md DATE SIGNED 1-15-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit

DATE THEREOF: 1-9-53

NAME OF CEMETERY OR CREMATORY: Millers Chapel

LOCATION (City, town, or county) (State): Lee County, Virginia

DATE REC'D BY LOCAL REG. 1/14/53

REGISTRAR'S SIGNATURE:

24. FUNERAL DIRECTOR: Robert L. Humphrey ADDRESS Bethesda, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Montgomery; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda,; LENGTH OF STAY (In this place): DOA; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Suburban Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rockville; STREET ADDRESS (If rural, give location): 5903 Coral Sea Ave.

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Olan | Edwin | FORD | Jan | 22 | 19.. |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Single | Sep. 14, 1951 | 1 yrs. | 4 | 8 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Infant | | Bethesda | US |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Emerson Eugene Ford | Barbara Ryan |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| No | None | E.E.Ford- Item 2 |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Asphyxia due to Sonicture | Dead on Arrival |
| 721.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. | (b) | |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☒ No ☐ |

| 21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | Home | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Emmet J. Bennett | M.D. | Gaithersburg, Md. | January 22, 1953 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1-26-53 | Arlington National | Arlington, Virginia |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 1/24/53 | [illegible] | Robert H. Dunphey | Bethesda, Md. |

RECEIVED
JAN 27 1953

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural
LENGTH OF STAY (in this place) 3 wks - 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Waverley Sanitarium

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE California — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Los Angeles ✓
STREET ADDRESS (If rural, give location) Santa Monica Blvd - Hotel Harvey

3. NAME OF DECEASED (Type or Print): (First) Edgar (Middle) Raymond (Last) Frisby
4. DATE OF DEATH: (Month) January (Day) 10 (Year) 1953

5. SEX: male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: Oct. 10 1877
9. AGE last birthday: 75 yrs. If under 1 year: Months 3 Days — If under 24 hrs.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Civil Engineer
10b. KIND OF BUSINESS OR INDUSTRY: Civil engineering
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Edgar Frisby
14. MOTHER'S MAIDEN NAME: Laura Ebert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS: Phyllis Frisby Yelverton

18. MEDICAL CERTIFICATION 4413-27th St. Arlington, Va.

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Bronchopneumonia | 48 hours |
| 331 K Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Arterio-sclerosis - Cerebral hemorrh | 10 years |
| | (c) Parkinson's disease — | 9 years |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | — | |

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 2, 1953, to Jan. 10, 1953, that I last saw the deceased alive on Jan. 10th 1953, and that death occurred at 8:30 P. m., from the causes and on the date stated above.

SIGNATURE: Wheeler O. Huff (Degree or title) M.D. ADDRESS 4524 - Maple Ave., Bethesda 14, Md. DATE SIGNED Jan. 10 - 1953.

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) | DATE THEREOF 1/13/53 | NAME OF CEMETERY OR CREMATORY Oak Hill | LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. 1/12/53 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR 307 Buchanan | ADDRESS 307 Mt. Vernon Ave. Alexandria, Va.

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
LENGTH OF STAY (In this place) D. O. A
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Monty
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chevy Chase
STREET ADDRESS (If rural, give location) 4 E. Irving St.

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) (Last) Futterer

4. DATE OF DEATH: (Month) Jan (Day) 28 (Year) 1953

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Mar 8 1904

9. AGE last birthday: 48 49 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lawyer

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Francis Futterer

14. MOTHER'S MAIDEN NAME: Eliza Mayhew

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): W.W. II

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Jas P. Spellbring 5018 - 30th Ave N.W. Wash DC.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

916.0

Immediate cause (a) Asphyxia due to inhalation of

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) smoke and fumes

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: 1st & 2nd degree burns of legs + forehead

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY home
(CITY OR TOWN) Chevy Chase (COUNTY) Monty (STATE) Md
TIME OF INJURY (Month) (Day) (Year) (Hour) Jan 28 53 10:30 p m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? house fire

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Frank O. Brochart M.D. Hitchester Md 1-29-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 2/2/53
NAME OF CEMETERY OR CREMATORY: Arlington nat'l
LOCATION (City, town, or county) (State): Arlington Va.

DATE REC'D BY LOCAL REG.: 1/29/53
REGISTRAR'S SIGNATURE: Assistant Registrar
24. FUNERAL DIRECTOR: Joseph Gawler's Sons
ADDRESS: Wash 1756 Pa. Ave, N.W.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington
LENGTH OF STAY (In this place) ___ dys.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Kensington Gardens Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE D.C. — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 1202 K St N.W. ✓

3. NAME OF DECEASED (Type or Print): (First) Mildred (Middle) A. (Last) Galliher
4. DATE OF DEATH (Month) 1/24 (Day) (Year) 53 19

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WID.
8. DATE OF BIRTH: Oct 6
9. AGE last birthday: 8 8 yrs. — If under 1 year: Months ___ Days ___ — If under 24 hrs.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife.
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William K. Galliher
14. MOTHER'S MAIDEN NAME: Mary E. Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: No
17. INFORMANT AND ADDRESS: Nursing Home, Kensington Md.

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardiac failure — 1 hours

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis — 2-4 yrs.

(c) [illegible] — 3 days

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. essential hypertension

19a. DATE OF OPERATION: ___
19b. MAJOR FINDINGS OF OPERATION: ___
20. AUTOPSY? Yes ☐ ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): ___
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ___ (CITY OR TOWN) ___ (COUNTY) ___ (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.: ___
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? ___

22. I hereby certify that I attended the deceased from Dec., 1947, to Jan. 24, 1953, that I last saw the deceased alive on 1/22, 1953, and that death occurred at 1:20 p. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) [illegible] MD — ADDRESS 4701 Cathedral Ave. N.W. — DATE SIGNED 1/24/53

23. BURIAL, CREMATION, REMOVAL (Specify): ___
DATE THEREOF: 1-24-53
NAME OF CEMETERY OR CREMATORY: Gate of Heaven
LOCATION (City, town, or county) (State): Silver Spring, Md.

DATE REC'D BY LOCAL REG. 1-26-53
REGISTRAR'S SIGNATURE: Frances Fuller
24. FUNERAL DIRECTOR: [illegible] — ADDRESS 5732 Connecticut Ave. N.W.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Wt. 8oz. 18-20wks. (Premature)

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH**
COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda
MARYLAND
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Suburban Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: Maryland
COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: BETHESDA
STREET ADDRESS (If rural, give location): 7816 Tilbury Street.

**3. NAME OF DECEASED** (Type or Print): (First) Baby (Middle) Pamela Gail (Last) Gaver

**4. DATE OF DEATH**: (Month) January (Day) 26th (Year) 1953

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED.** (Specify): —

**8. DATE OF BIRTH**: 1/26/53

**9. AGE last birthday**: — yrs. If under 1 year: Months —, Days —, If under 24 hrs.: Hours —, Min. 5 45

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): —

**10b. KIND OF BUSINESS OR INDUSTRY**: —

**11. BIRTHPLACE** (State or foreign country): Maryland

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Austin Leslie Gaver

**14. MOTHER'S MAIDEN NAME**: Edna May Mercer

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): — (If yes, give war or dates of service): —

**16. SOCIAL SECURITY No.**: —

**17. INFORMANT AND ADDRESS**: Father

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — ONSET AND DEATH

Immediate cause (a) Prematurity.

Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) —

(c) —

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION**:

**19b. MAJOR FINDINGS OF OPERATION**:

**20. AUTOPSY?** Yes ☐ No ☒

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 26, 1953, to Jan 26, 1953, that I last saw the deceased alive on Jan 26, 1953, and that death occurred at 6 P m., from the causes and on the date stated above.

SIGNATURE: Julian Foyl M.D. (Degree or title) ADDRESS: 8341 Colesville Rd. Silver Spring Md. DATE SIGNED: 1/26/53

**23. BURIAL, CREMATION, REMOVAL** (Specify): — DATE THEREOF: 1/28/53 NAME OF CEMETERY OR CREMATORY: Suburban Hospital LOCATION (City, town, or county) (State): Bethesda, Md.

DATE REC'D BY LOCAL REG. 1/29 REGISTRAR'S SIGNATURE: —

**24. FUNERAL DIRECTOR** ADDRESS: Amelia Manns, Supt.

2013243190

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 2-17

1. PLACE OF DEATH
COUNTY: Montgomery — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Spring
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 815 Sligo Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Spring
STREET ADDRESS (If rural, give location): 815 Sligo Avenue

3. NAME OF DECEASED (Type or Print): (First) EDWARD (Middle) A. (Last) GAYLOR

4. DATE OF DEATH: (Month) January (Day) 1 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Sept. 17, 1873

9. AGE last birthday: 79 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Building Inspector for the State of Md.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John C. Gaylor

14. MOTHER'S MAIDEN NAME: Mary M. Anderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 214-03-9503

17. INFORMANT AND ADDRESS: E. Claude Gaylor, Laurel, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Pulmonary Edema | 1 week |
| Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Carcinoma of Prostate with metastasis. | 6 years. |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pathologic fracture lumbar spine due to fall. — 4 yrs

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Silver Spring Md (CITY OR TOWN) Mont. Md (COUNTY) (STATE)

TIME OF INJURY: (Month) (Day) (Year) 1948 (Hour) m.

INJURY OCCURRED While at Work ☑ Not While At work ☐

HOW DID INJURY OCCUR? Due to fall.

22. I hereby certify that I attended the deceased from Aug 15, 1949, to Jan 1, 1953, that I last saw the deceased alive on Jan 1, 1953, and that death occurred at 1:42 a.m., from the causes and on the date stated above.

SIGNATURE: H. B. Orleans (Degree or title) MD ADDRESS: 9500 Colesville Rd DATE SIGNED: 1-1-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 1/3/53 — NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery — LOCATION (City, town, or county) (State): Washington, D. C.

DATE REC'D BY LOCAL REG.: Jan 5, 1953 — REGISTRAR'S SIGNATURE: Frances Potter

24. FUNERAL DIRECTOR: Warner E. Pumphrey — ADDRESS: 8434 Ga. Ave. Silver Spring, Md.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JAN 7
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 2-16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH — COUNTY: Montgomery — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Chevy Chase
LENGTH OF STAY (in this place): 2 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 4617 DeRussey Pkwy.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Montg.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Chevy Chase
STREET ADDRESS (If rural, give location): 4617 DeRussey Pkwy.,

3. NAME OF DECEASED (Type or Print): (First) GRACE (Middle) PITNEY (Last) GEERY
4. DATE OF DEATH: (Month) Jan (Day) 21st (Year) 1953

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 12/22/53 10
9. AGE last birthday: 42 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Kansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Walter S. Pitney
14. MOTHER'S MAIDEN NAME: Katherine Doty

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Clifford R. Geery, Bethesda, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Generalized bony metastasis

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) from primary adenocarcinoma

(c) of left breast - diagnosed 1 yr ago

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept., 19 52, to Jan., 19 53, that I last saw the deceased alive on 1-21, 19 53, and that death occurred at 11:00 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Wm. M. Ballinger M.D. 1801 Eye Wash. D.C. 1-22-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Jan 24, 1953
NAME OF CEMETERY OR CREMATORY: Nat. Memorial Park
LOCATION (City, town, or county) (State): Falls Church, Virginia

DATE REC'D BY LOCAL REG.: 1/24/53
REGISTRAR'S SIGNATURE
24. FUNERAL DIRECTOR: Robert A. Pumphrey ADDRESS: Bethesda, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7912 Radnor Lane

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
STREET ADDRESS (If rural, give location) 7912 Radnor Lane

3. NAME OF DECEASED (Type or Print) (First) GISELA (Middle) HEIM (Last) GERBERICH

4. DATE OF DEATH (Month) (Day) (Year) Jan. 16, 1953

5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH 6-7-1897 | 9. AGE last birthday 55 yrs. | If under 1 year Months 7 Days 9 | If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Hungary
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Stephen Heim
14. MOTHER'S MAIDEN NAME Theresa Brigitte

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT AND ADDRESS Albert H. Gerberich-Item # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Myocardial Decompensation | 12 hours |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) R heumatic Heart disease | 20 yrs? |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1952, to Nov. 9, 1952, that I last saw the deceased alive on 11-9, 1952, and that death occurred at 9:30 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

William N. Gasel M.D. 8016 Old Georgetown Rd Beth. Md 1-17-53.

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF 1-20-53 | NAME OF CEMETERY OR CREMATORY Atglen Church Cem. | LOCATION (City, town, or county) (State) Atglen, Pennsylvania

DATE REC'D BY LOCAL REG. 1-20-53 | REGISTRAR'S SIGNATURE | NAME OF FUNERAL DIRECTOR Robert L. Pumphrey | ADDRESS Bethesda, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 217

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Montgomery
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town) Olney
MARYLAND LENGTH OF STAY (in this place) 18 hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Montgomery County General Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY P. George
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ayattsville (Lewisdale)
STREET ADDRESS (If rural give location) 2206 Beechwood Rd. ✓

3. NAME OF DECEASED: (Type or Print) (First) Marion (Middle) A (Last) Gibson

4. DATE OF DEATH: (Month) Jan. (Day) 8 (Year) 1953

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W

8. DATE OF BIRTH: May 10 1870

9. AGE last birthday: 82 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Merchant

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Josiah J. Gibson

14. MOTHER'S MAIDEN NAME: C. Armstrong

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO.: No

17. INFORMANT & ADDRESS: J. A. Gibson Same address

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Congestive heart failure — Interval Between Onset And Death: 6 days

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Chronic myocardiotis — 5 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 25, 1952, to Jan 8, 1953, that I last saw the deceased alive on Jan 8, 1953, and that death occurred at 4:10 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
A. D. Bonjaut M.D. Sandy Spring Md. 1/8/53

23. BURIAL, CREMATION, REMOVAL (Specify) Interment — DATE THEREOF 1/8/53 — NAME OF CEMETERY OR CREMATORY Sligo Creek — LOCATION (City, town or county) (State) Silver Spring Md

DATE REC'D BY LOCAL REGISTRAR 1-8-53 — REGISTRAR'S SIGNATURE Gertrude B Fawler

24. FUNERAL DIRECTOR ADDRESS Warner E. Dempsey 8434 Ga ave Silver Spring Md

VS. A15

JAN 1
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 4845 DelRay Ave

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda
STREET ADDRESS (If rural, give location): 4845 DelRay Ave.

3. NAME OF DECEASED (Type or Print): (First) CLARENCE (Middle) LYLE (Last) GILBERT

4. DATE OF DEATH (Month) (Day) (Year): Jan. 5, 1953 19

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 3-21-1882

9. AGE last birthday: 70 yrs. — If under 1 year: Months: 9 Days: 14 — If under 24 hrs.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired- Paint Bus.

10b. KIND OF BUSINESS OR INDUSTRY: Self Emp.

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: James B. Gilbert

14. MOTHER'S MAIDEN NAME: Belle U. Grady

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: yes

17. INFORMANT AND ADDRESS: James B. Gilbert 6804 Meadow Lane Chevy Chase, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary occlusion — sudden death

420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) arterio-sclerosis — 2 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED

Frank J. Bouchart M.D. Gaithersburg Md 1-5-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: 1-7-53 | NAME OF CEMETERY OR CREMATORY: Parklawn | LOCATION (City, town, or county) (State): Montg. Co. Maryland

DATE REC'D BY LOCAL REG. 1/7/53 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR: Robert M. Umpfrey | ADDRESS: Bethesda, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 212

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Barnesville
LENGTH OF STAY (in this place) 50 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Montg
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Barnesville
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) John Forrest (Middle) Gott (Last)

4. DATE OF DEATH: (Month) Jan (Day) 27 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (write) Married

8. DATE OF BIRTH: Sept 10-1879

9. AGE last birthday: 73 yrs. IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Retired, Agric. dept. U.S. Govt.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: John S. Gott

14. MOTHER'S MAIDEN NAME: Florence Hays

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mrs Forrest Gott, Barnesville, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion — Interval Between Onset And Death: 10 minutes

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. 42

(b) Hypertensive-Arteriosclerotic Cardiovascular Disease — 10 years

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1950, to 27 Jan., 1953, that I last saw the deceased alive on 27 Jan, 1953, and that death occurred at 6:45 AM., from the causes and on the date stated above.

SIGNATURE (Degree or title) Gordon M. Smith, M. D. ADDRESS Barnesville DATE SIGNED 27 Jan. 53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF Jan 30-53

NAME OF CEMETERY OR CREMATORY Monocacy

LOCATION (City, town, or county) Beallsville (State) Md

DATE REC'D BY LOCAL REGISTRAR Jan 28, 1953

REGISTRAR'S SIGNATURE Charles W. Elgin per DJE

24. FUNERAL DIRECTOR ADDRESS William B. Hilton Barnesville, Md.

VS. A15

Item 6 Film 150 2/5/53 wlw

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 423

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
COUNTY: Montgomery — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Takoma Park
LENGTH OF STAY (in this place): 47 hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Washington Sanitarium + Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Takoma Park
STREET ADDRESS (If rural give location): 6514 Westmoreland Ave

**3. NAME OF DECEASED (Type or Print):** (First) Alice (Middle) Maud (Last) Hall

**4. DATE OF DEATH:** (Month) 1 (Day) 17 (Year) 1953

**5. SEX:** Female

**6. COLOR OR RACE:** American White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):** Widow

**8. DATE OF BIRTH:** 10/29/1892

**9. AGE last birthday:** 60 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY:** —

**11. BIRTHPLACE** (State or foreign country): Washington, D.C.

**12. CITIZEN OF WHAT COUNTRY?** U.S.A.

**13. FATHER'S NAME:** William Pickles

**14. MOTHER'S MAIDEN NAME:** Mary Ann Hutchison

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) NO (If Yes, give war or dates of service)

**16. SOCIAL SECURITY NO.:**

**17. INFORMANT & ADDRESS:** Hospital Chart

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420 Immediate cause (a) Arteriosclerotic Heart Disease — Interval Between Onset And Death: 6 years

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Congestive Heart Failure — 2 years
DUE TO (c) Uremia — 6 years.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:**

**19b. MAJOR FINDINGS OF OPERATION**

**20. AUTOPSY?** Yes ☐ No ☐

**21.** ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 17 1952, to Jan 17 1953, that I last saw the deceased alive on Jan 17, 1953, and that death occurred at 5:00 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): Boris Rabkin M.D. — ADDRESS: 1200 Lebanon Street Silver Spring Md — DATE SIGNED: Jan 17 '53

**23.** BURIAL / CREMATION / REMOVAL (Specify) — DATE THEREOF: 1/22/53 — NAME OF CEMETERY OR CREMATORY: Methodist Cem. — LOCATION (City, town, or county): Colesville (State): Md.

DATE REC'D BY LOCAL REGISTRAR: Jan. 17-1953 — REGISTRAR'S SIGNATURE: J. Holton Dodd

**24.** FUNERAL DIRECTOR: The D. H. Hines Co — ADDRESS: 2901-14th St NW Washington D.C.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN Bethesda
LENGTH OF STAY (in this place) 15 hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville
STREET ADDRESS (If rural, give location) R.F.D. # 2.

3. NAME OF DECEASED (Type or Print) (First) George (Middle) Edward (Last) Hall

4. DATE OF DEATH (Month) Jan. (Day) 12 (Year) 19 53

5. SEX Male
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH Jan 12-1953
9. AGE last birthday yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min. 15

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME George Young
14. MOTHER'S MAIDEN NAME Betty Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Mother

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Acute myocardium

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Pneumonia Coronary

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/12/53, 19..., to 1/12, 1953, that I last saw the deceased alive on 1/12/53, 19..., and that death occurred at 6.35 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Joseph Pence M.D. Resident Physician 1/12/53

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF 1/14/53 | NAME OF CEMETERY OR CREMATORY Suburban Hospital | LOCATION (City, town, or county) (State) Bethesda Maryland

DATE REC'D BY LOCAL REG. 1/16/53 | REGISTRAR'S SIGNATURE [illegible] | 24. FUNERAL DIRECTOR Amelia Mancy ADDRESS [illegible]

2-13/7/46V

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

1 PLACE OF DEATH:
COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen mar Park
LENGTH OF STAY (in this place) 9 mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5908 NAMAKAGAN

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Mont
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS So (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) ALICE (Middle) M (Last) HAPP

4. DATE OF DEATH: (Month) 1 (Day) 21 (Year) 1953

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):
8. DATE OF BIRTH: 12-13-1865
9. AGE last birthday: 87 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Washington DC
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry C. Espey
14. MOTHER'S MAIDEN NAME: mary E Bridget

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)
(If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Henry Kimball-Wanoboygon

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset And Death |
|---|---|---|
| Immediate cause | (a) Coronary Thrombosis | 8 hours |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. | (b) DUE TO Cerebral anemia | or 8 years |
| | (c) DUE TO Arteriosclerotic Heart Disease | or 5 years |

I 20 C

II OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) No
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January, 1948, to January 21, 1953 that I last saw the deceased alive on Jan 21, 1953 and that death occurred at 3:30 P.M. from the causes and on the date stated above.
SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Michael M. Greene MD 1150 Conn - D.C. 1-21-53

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF 1-23-53 NAME OF CEMETERY OR CREMATORY Fort Lincoln LOCATION (City, town, or county) (State) Prince George's Co. Md
ADDRESS

DATE REC'D BY LOCAL REGISTRAR 1/22/53 REGISTRAR'S SIGNATURE Bessie M. Thompson
24. FUNERAL DIRECTOR The S. H. Hines Co 2901-14th St N.W. DC.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 218

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V.S. A15A

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington Grove; LENGTH OF STAY (In this place) 4 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS 117 Grove Rd

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Monty; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington Grove; STREET ADDRESS (If rural, give location) 117 Grove Rd

3. NAME OF DECEASED (Type or Print): (First) William (Middle) Henry (Last) Helms

4. DATE OF DEATH: (Month) Jan (Day) 9 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Sept 14 '62

9. AGE last birthday: 90 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Insurance

11. BIRTHPLACE (State or foreign country): Pa

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Andrew D. Helms

14. MOTHER'S MAIDEN NAME: Mary Ann Spears

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Harry A. Helms - Wash Grove Md

### 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Acute cardiac failure | 6 hrs |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Chronic myocarditis | 2 mo |
| | (c) | |

4-23-2

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Thos J. Brosnihan M.D. Gaithersburg Md 1-9-53

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: 1-12-53

NAME OF CEMETERY OR CREMATORY: Fernwood - Cem.

LOCATION (City, town, or county) (State): Bethesda, Md.

DATE REC'D BY LOCAL REG.: Jan 9 - 1953

REGISTRAR'S SIGNATURE: Arnold L. Cook

24. FUNERAL DIRECTOR: Wm. J. H. Heim & Son

ADDRESS: Washington D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH:**

COUNTY: Montgomery — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda

LENGTH OF STAY (in this place): 2 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Suburban Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

STATE: Maryland — COUNTY: Montgomery

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Spring

STREET ADDRESS (If rural give location): 11405 Galt Avenue, Wheaton Hills

**3. NAME OF DECEASED:** (Type or Print) (First) Helen (Middle) Marie (Last) Hile

**4. DATE OF DEATH:** (Month) Jan. (Day) 1 (Year) 19 53

| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | white | married | Feb. 17, 1900 | 52 yrs. | | |

| 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Bookkeeper | U.S. Treasury Dept. | Washington, D.C. | U.S.A. |

**13. FATHER'S NAME:** Frank M. Howard

**14. MOTHER'S MAIDEN NAME:** Jennie Reynolds

| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY No.: | 17. INFORMANT & ADDRESS: |
|---|---|---|---|
| no | | — | Lewis K. Hile - (Husband) - 11405 Galt Avenue |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

490X

Immediate cause — (a) Pneumonia, lobar, right — DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. — (b) Rheumatic Heart Disease — DUE TO

(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes X No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/28, 1952, to 1/1, 1953, that I last saw the deceased alive on 12/31, 1952, and that death occurred at 12 45 pm 1/1/53, from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Belden R. Leap | M.D. | Silver Spring Md. | 1/1/53 |

| 23. BURIAL, ~~CREMATION~~, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Private - Burial | 1-6-1953 | Arlington Natl. | Va. | D.C. |

| DATE REC'D BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 1/2/53 | Bessie M. Thompson | The S.H. Hines Funeral Home | 1407 F St. NW |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 223

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Montgomery County MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town Takoma Park, Md.
LENGTH OF STAY (in this place) 12 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Sanitarium and Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring, Maryland
STREET ADDRESS (If rural give location) 705 Dale Drive

3. NAME OF DECEASED: (Type or Print) (First) James (Middle) William (Last) Hirst

4. DATE OF DEATH: (Month) Jan. (Day) 23 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 6-27-85

9. AGE last birthday: 67 yrs. IF UNDER 1 YEAR: Months 7 Days 4 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life even if retired): Retired Plate Printer

10b. KIND OF BUSINESS OR INDUSTRY: Bur. of Engraving

11 BIRTHPLACE (State or foreign country): St. Louis, Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James William Hirst Sr.

14. MOTHER'S MAIDEN NAME: Mary Ellen Neely

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NONE (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS: Mary C. Clarke R.N. 9107 Flower Ave. Silver Spring, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiac failure, pulmonary edema, pleural effusion — Interval Between Onset And Death: 2 wks.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) Coronary sclerosis, extreme, right and left — 7 months

DUE TO (c) Arteriosclerosis generalized, severe — years.

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Acute exacerbation of chronic glomerulonephritis 2 wks.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-12 ,1953, to 1-23, 1953, that I last saw the deceased alive on 1-23, 1953, and that death occurred at 11:50 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Arthur R. Bergman, M.D. ADDRESS 8811 Colesville Rd, Silver Spring, Md. DATE SIGNED 1-23 53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 1/26/53

NAME OF CEMETERY OR CREMATORY Fairfax Cemetery

LOCATION (City, town, or county) Fairfax County, Virginia (State)

DATE REC'D BY LOCAL REGISTRAR Jan. 28. 1953

REGISTRAR'S SIGNATURE J. Hirst Dodd

24. FUNERAL DIRECTOR Warner & Turpin

ADDRESS 8434 Georgia Ave. Silver Spring, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully is especially important. Physician please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY MONTGOMERY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SILVER SPRING | LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 8907 COLESVILLE RD.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN WASHINGTON D.C.
STREET ADDRESS (If rural, give location) 3905 26TH ST. NE

3. NAME OF DECEASED (Type or Print): (First) JOSEPH (Middle) HOWARD (Last) HOLLAND
4. DATE OF DEATH: (Month) JAN (Day) 18 (Year) 1953
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: MAY 31 1870
9. AGE last birthday: 82 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): [illegible]
10b. KIND OF BUSINESS OR INDUSTRY: D.C. GOVT.
11. BIRTHPLACE (State or foreign country): STOCKPORT ENGLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: JOHN HOLLAND
14. MOTHER'S MAIDEN NAME: ELIZABETH HOLLAND
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): NO
16. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT AND ADDRESS: MARIAN HOLLAND

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Vascular Accident — Interval Between Onset and Death: 4 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Arteriosclerotic Heart Disease — 1 year

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 52, to Jan 53, that I last saw the deceased alive on 17 Jan, 1953, and that death occurred at 8:40 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED
Jane Haak M.D. 8801 Colesville Rd Silver Spring Md. 19 Jan 53

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
DATE: JAN 21 1953
NAME OF CEMETERY OR CREMATORY: ROCK CREEK
LOCATION (City, town, or county) (State): WASHINGTON DC
DATE REC'D BY LOCAL REG.: 1-19-53
REGISTRAR'S SIGNATURE: Frances Cotter
24. FUNERAL DIRECTOR: W.W. CHAMBERS & ADDRESS: 1400 CHAPIN ST NW WASH DC

Item 10 or 14, Feb. #150-1/14/53-mmh

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH:**
COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town: Bethesda — LENGTH OF STAY (in this place): 2 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Suburban Hospital 8400 Old Georgetown Rd.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE Maryland — COUNTY Montgomery
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
STREET ADDRESS (If rural, give location): 519 Park Lane

**3. NAME OF DECEASED:** (Type or Print) (First) John (Middle) Joseph (Last) Hopfield

**4. DATE OF DEATH:** (Month) (Day) (Year) 8 1953

**5. SEX:** Male

**6. COLOR OR RACE:** White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):** Married

**8. DATE OF BIRTH:** July 8 1891

**9. AGE last birthday:** 61 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION.** Give kind of work done during most of working life, even if retired: Physicist

**10b. KIND OF BUSINESS OR INDUSTRY:** atomic research U.S. Govt.

**11. BIRTHPLACE** (State or foreign country): Plock, Poland

**12. CITIZEN OF WHAT COUNTRY?** U.S.A.

**13. FATHER'S NAME:** Stanley Hopfield

**14. MOTHER'S MAIDEN NAME:** unknown

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) no (If Yes, give war or dates of service)

**16. SOCIAL SECURITY NO.:**

**17. INFORMANT & ADDRESS:**

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) Coronary sclerosis with terminal coma — Interval Between Onset And Death: 4 hr.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Coronary sclerosis of 6th coronary Vessel — 10 yr ?
DUE TO (c) Angina of effort — 1 yr

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:**

**19b. MAJOR FINDINGS OF OPERATION**

**20. AUTOPSY?** Yes ☒ No ☐

**21.** ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

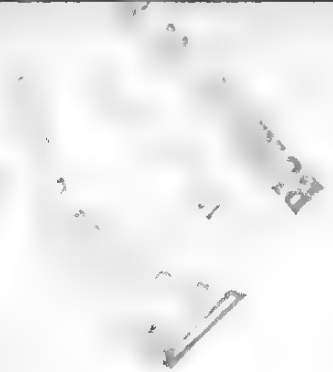
22. I hereby certify that I attended the deceased from ..., 1946., to 8 Jan ..., 1953, that I last saw the deceased alive on 8 Jan, 1953, and that death occurred at 5:30 A.M from the causes and on the date stated above.

SIGNATURE: John S Ball (Degree or title): M.D. ADDRESS: 7936 Bungtown Rd Bethesda Md DATE SIGNED: 8 Jan 53

**23.** BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 1-10-1953 — NAME OF CEMETERY OR CREMATORY: Parklawn — LOCATION (City, town, or county) (State): Montgomery Co., Md.

DATE REC'D BY LOCAL REGISTRAR: 1/9/53 — REGISTRAR'S SIGNATURE:

**24.** FUNERAL DIRECTOR: Robert A. Umphrey — ADDRESS: Bethesda, Md.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH — COUNTY: Montgomery — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Spring
LENGTH OF STAY (in this place): 3 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: CEDARCROFT SANITARIUM

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda
STREET ADDRESS (If rural, give location): 4939 St Elmo Ave

3. NAME OF DECEASED (Type or Print): (First) Willie (Middle) Hopkins (Last) Hoyle

4. DATE OF DEATH: (Month) Jan (Day) 20, (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Dec 8, 1899

9. AGE last birthday: 54 53 yrs.
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber

10b. KIND OF BUSINESS OR INDUSTRY: Self Emp.

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: (First unknown) Hoyle

14. MOTHER'S MAIDEN NAME: Mary (Last unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): II

16. SOCIAL SECURITY NO.: 579-10-5199

17. INFORMANT AND ADDRESS: (Wife) Mildred L. 4939 St Elmo Ave, Bethesda, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Angina pectoris

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension

(c) Coronary sclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 17, 1953, to Jan 20, 1953, that I last saw the deceased alive on Jan 19, 1953, and that death occurred at 8:15 A. m., from the causes and on the date stated above.

SIGNATURE: R. B. Thibadeau (Degree or title) ADDRESS: R. B. THIBADEAU, M. D. CEDARCROFT SANITARIUM, S. S. MD. DATE SIGNED: Jan 20, 1953

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 1-23-53
NAME OF CEMETERY OR CREMATORY: Arlington National
LOCATION (City, town, or county) (State): Arlington, Va.

DATE REC'D BY LOCAL REG.: 1/21/53
REGISTRAR'S SIGNATURE: Frances Lotte
24. FUNERAL DIRECTOR: Robert A. Pumphrey
ADDRESS: Bethesda, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Montgomery; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington; LENGTH OF STAY (In this place) Life; HOSPITAL OR INSTITUTION OR STREET ADDRESS Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington; STREET ADDRESS (If rural, give location) 10004 Crestwood Drive

3. NAME OF DECEASED (Type or Print): (First) Lois (Middle) Anne (Last) Huston

4. DATE OF DEATH: (Month) Jan. (Day) 25 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Nov. 4, 1948

9. AGE last birthday: 4 yrs. If under 1 year: Months 2, Days 21; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Bethesda, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Richard Huston

14. MOTHER'S MAIDEN NAME: Patricia Mae Wilkinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: 10004 Crestwood Dr. John R. Huston, Kensington, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| + Immediate cause | (a) asphyxia | Sudden |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) acute tracheo-Bronchitis-pneumonitis | 1 day |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Emil G. Bauerfeind (Degree or title) Asst Dep Md Exam. ADDRESS Bethesda, Md DATE SIGNED 1/25/53

23. BURIAL, CREMATION, REMOVAL (Specify): Transit-Burial; DATE THEREOF 1-28-53; NAME OF CEMETERY OR CREMATORY: Union Cemetery; LOCATION (City, town, or county): Columbus, (State) Ohio

DATE REC'D BY LOCAL REG. 1/26/53; REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR: Ronald D. Pumphrey ADDRESS Bethesda, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH
COUNTY: Montgomery — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Spring
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: State Side Drive

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Spring
STREET ADDRESS (If rural, give location): State Side Drive

3. NAME OF DECEASED (Type or Print): (First) JAMES (Middle) A. (Last) HYSLOP

4. DATE OF DEATH: (Month) Jan (Day) 16 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: July 7, 1884

9. AGE last birthday: 68 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Entomologist - U. S. Gov't. Scientist

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Chicago, Illinois

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Charles G. Hyslop

14. MOTHER'S MAIDEN NAME: Mary Garvey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Jas. A. Hyslop, 5525 Oakmont Dr., Bethesda, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Cerebral Arteriosclerosis with repeated | 3 YEARS |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) cerebral thromboses | |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Heart Disease — 6 YEARS

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1947, to Jan, 1953, that I last saw the deceased alive on Jan 16, 1953, and that death occurred at 8:45 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Arthur B. Rosenbaum, M.D. 1025 Vermont Ave & W Wash Dc · Jan 16 53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Jan. 19, 1953

NAME OF CEMETERY OR CREMATORY: Geo. Washington Cemetery

LOCATION (City, town, or county) (State): Riggs Rd., Pr. Geo. Co., Md.

DATE REC'D BY LOCAL REG.: 1-19-53

REGISTRAR'S SIGNATURE: Frances Potter

24. FUNERAL DIRECTOR ADDRESS: Warner E. Pumphrey, Silver Spring, Md.

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS x x x

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Prince Georges
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Camp Springs
STREET ADDRESS (If rural, give location) 5677 - Auth road ✓

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| MAX | BRUNO | JACOBI | Jan. | 1 | 1953 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| MALE | WHITE | married | 7/23/1880 | 72 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Mechanic | Naval Research Lab | Germany | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Unknown | Unknown |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| no | None | Frank P. Wilson Route #1 R.F.D. Box 19 - Good Springs road. Hyattsville Md. |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Metastatic carcinoma to brain & Bone | 6 mo. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Carcinoma of prostate | 1 yr. |
| | (c) Carcinoma of lung | 10 mo. |

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | Yes ☐ No ☑ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from Dec. 27, 1952 to Jan. 1, 1953 that I last saw the deceased alive on Dec. 31, 1952, and that death occurred at 10:35 a.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| [signature] | M.D. | 1009 Lyttonsville Rd. Silver Spring Md. | Jan. 1, 1953 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1/3/1953 | Wash. Natl. Mem. | Suitland Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 1-5-53 | [signature] | H. H. Chambers Co. | 517-11th st. N.W. |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 217

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Olney, Md.
LENGTH OF STAY (in this place) 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Montgomery Co. Gen. Hosp. Inc.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Derwood RFD 1
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) George (Middle) Noel (Last) Jefferies

4. DATE OF DEATH: (Month) January (Day) 9 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: June 13, 1875

9. AGE last birthday: 77 yrs. IF UNDER 1 YEAR: Months 6 Days 26 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Laborer.

10b. KIND OF BUSINESS OR INDUSTRY: Farmwork -

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Jefferies

14. MOTHER'S MAIDEN NAME: Mary Hitt

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Alice Jeffries. Derwood R.F.D. 1

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion — Interval Between Onset And Death: 1 hour

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Postoperative Shock — 3 hours
DUE TO (c) Arteriosclerotic Heart Disease — yrs.

6 wks

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 1/9/53

19b. MAJOR FINDINGS OF OPERATION: Benign Prostatic Hypertrophy

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/27, 1952, to 1/9, 1953, that I last saw the deceased alive on 1/9, 1953, and that death occurred at 12:48 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Gregory MD ADDRESS Sandy Spring Md. DATE SIGNED 1/9/53

BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 1-13-53

NAME OF CEMETERY OR CREMATORY St. Louis

LOCATION (City, town, or county) (State) Clopper, Md.

DATE REC'D BY LOCAL REGISTRAR Jan. 12, 1953

REGISTRAR'S SIGNATURE Absalom G. Cooke

24. FUNERAL DIRECTOR E. C. Fortune ADDRESS Gaithersburg Md.

1-13-53 Gertrude B Fowler 217

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 214

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
LENGTH OF STAY (in this place) 18 Mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS CLEARCROFT SANITARIUM

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE DC — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN WASHINGTON DC ✓
STREET ADDRESS (If rural, give location) 2129 Florida Ave N.W.

3. NAME OF DECEASED (Type or Print): (First) Frances (Middle) Casey (Last) Jermyn

4. DATE OF DEATH: (Month) Jan (Day) 25 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: April 5, 1870

9. AGE last birthday: 82 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Ireland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Casey

14. MOTHER'S MAIDEN NAME: Sarah Sherlock

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) 1918-19

16. SOCIAL SECURITY No. None

17. INFORMANT AND ADDRESS (daughter) Marion Jermyn, 2129 Florida Avenue, N. W.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Myocarditis

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis

(c) Senility

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 13 1951, to Jan 25, 1953, that I last saw the deceased alive on Jan 25, 1953, and that death occurred at 11:15 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Richard B. Tildesley MD CLEARCROFT SANITARIUM Jan. 25, 1953

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF 1/27/53 — NAME OF CEMETERY OR CREMATORY Arlington Nat'l. — LOCATION (City, town, or county) (State) Fort Myer Virginia

DATE REC'D BY LOCAL REG. 1-26-53 — REGISTRAR'S SIGNATURE Frances Tobin

24. FUNERAL DIRECTOR — ADDRESS Jas Sanderson 1756 Kalorama NW Washington DC

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda, Rural
LENGTH OF STAY (in this place): 4 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S.Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: District Of Columbia — COUNTY: ———
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Washington
STREET ADDRESS (If rural give location): 1211 "N" Street N.W.

3. NAME OF DECEASED: (Type or Print) (First) Charles (Middle) Joseph (Last) JOHNSON

4. DATE OF DEATH: (Month) January (Day) 31 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: September 10,1879

9. AGE last birthday: 73 yrs. IF UNDER 1 YEAR: Months 4 Days 21 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Mariner

10b. KIND OF BUSINESS OR INDUSTRY: U.S.Navy

11. BIRTHPLACE (State or foreign country): Newport, Rhode Island

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John JOHNSON

14. MOTHER'S MAIDEN NAME: Margaret SULLIVAN

15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unk.): Yes — (If Yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: ———

17. INFORMANT & ADDRESS: SISTER: Mary Agnes JOHNSEN, 1709 S.W. 23rd.Terrace, Miami, Florida

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) CEREBRAL VASCULAR ACCIDENT — Interval Between Onset And Death: 8 HOURS

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. 502
(b) DUE TO TUBERCULOSIS, PULMONARY, FAR ADVANCED — UNKNOWN
(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 27, 1953, to Jan. 31, 1953, that I last saw the deceased alive on Jan. 31, 1953, and that death occurred at 10:00 PM, from the causes and on the date stated above.

SIGNATURE (Degree or title): P.R. JAMES, LT MC USN — ADDRESS: U.S. Naval Hospital, Bethesda, Maryland — DATE SIGNED: February 2, 1953

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 5 Feb. 1953 — EREOF — NAME OF CEMETERY OR CREMATORY: Arlington National — LOCATION (City, town, or county) (State): Arlington, Virginia.

DATE REC'D BY LOCAL REGISTRAR: February 2, 1953 — REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR — ADDRESS: S.H. HINES FUNERAL HOME, 2901 14th. Street N.W., Washington, D.C.

FEB 9

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 9826 Capitol View Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring; STREET ADDRESS (If rural, give location) 9826 Capitol View Ave.

3. NAME OF DECEASED (Type or Print): (First) Alice (Middle) Maude (Last) Jones

4. DATE OF DEATH: (Month) Jan. (Day) 29 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 7/31/1873

9. AGE last birthday: 79 yrs. If under 1 yr. Months / Days; If under 24 hrs. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Clar Drinking, Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Copeland Parker Jones

14. MOTHER'S MAIDEN NAME: Mary Maude Parkinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: no

17. INFORMANT AND ADDRESS: Miss Margarita F. Jones, 9826 Capitol View Ave. Silver Spring, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Carcinoma of Lung with Pleural Effusion | 1 mo |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) [illegible] with Hypertension | 10 yrs |
| | (c) Carcinoma of Breast | 3 yrs. |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Myocarditis with Hypertension

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-23, 1952, to 1-28, 1953, that I last saw the deceased alive on 1-28, 1953, and that death occurred at 1.00 A m., from the causes and on the date stated above.

SIGNATURE: M. Lucius (Degree or title) M.D. ADDRESS 9601 Georgia Ave DATE SIGNED 1/29/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE THEREOF: 1/31/53; NAME OF CEMETERY OR CREMATORY: Grace Episcopal Church Cemetery; LOCATION (City, town, or county) (State): Montgomery County, Md.

DATE REC'D BY LOCAL REG. 1/30/53; REGISTRAR'S SIGNATURE [illegible]

24. FUNERAL DIRECTOR: Elmer E. Dunphrey ADDRESS 8434 Georgia Ave., Silver Spring, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH
COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Spring
LENGTH OF STAY (In this place): MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: North West Branch

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Spring
STREET ADDRESS (If rural, give location): 10,410 Lorain Avenue

3. NAME OF DECEASED (Type or Print): (First) John (Middle) (Last) Keperis

4. DATE OF DEATH: (Month) Jan. (Day) 31 (Year) 19 53

5. SEX: Male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: 9/9/42

9. AGE last birthday: 10 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George J. Keperis

14. MOTHER'S MAIDEN NAME: Elizabeth DeRosa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY No.: none

17. INFORMANT AND ADDRESS: Mr. George J. Keperis, 10,410 Lorain Ave. Silver Spring, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Asphyxia due to drowning — Interval between onset and death: sudden death

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) 921.8

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Stream
(CITY OR TOWN): Silver Spring (COUNTY): Mont (STATE): Md
TIME OF INJURY (Month) (Day) (Year) (Hour): Jan 31-53-3:17 P m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR?: Fell in Stream - N.W. Branch

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): Frank J. Bontrait M.D.
ADDRESS: Gaithersburg Md
DATE SIGNED: 1-31-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 2/4/53
NAME OF CEMETERY OR CREMATORY: St. John's Cemetery
LOCATION (City, town, or county) (State): Montgomery County, Maryland

DATE REC'D BY LOCAL REG.: 2/2/53
REGISTRAR'S SIGNATURE: Frances Potter
24. FUNERAL DIRECTOR: Wilson Funeral Home
ADDRESS: 8434 Georgia Ave. Silver Spring, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. [illegible]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH:**
COUNTY [illegible] MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town: BETHESDA (RURAL)
LENGTH OF STAY (in this place): 40 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U. S. NAVAL HOSPITAL

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE DISTRICT OF COL. COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON, D. C.
STREET ADDRESS (If rural give location): 2120 16th Street, N.W. ✓

**3. NAME OF DECEASED:** (Type or Print) (First) RALPH (Middle) MILLER (Last) KETCHAM

**4. DATE OF DEATH:** (Month) January (Day) 19, (Year) 19 53

**5. SEX:** Male

**6. COLOR OR RACE:** White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):** Married

**8. DATE OF BIRTH:** 3-24-85

**9. AGE last birthday:** 67 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

**10a. USUAL OCCUPATION** Give kind of work done during most of working life, even if retired): Lawyer

**10b. KIND OF BUSINESS OR INDUSTRY:** - - - - - - -

**11. BIRTHPLACE** (State or foreign country): INDIANA

**12. CITIZEN OF WHAT COUNTRY?** U.S.

**13. FATHER'S NAME:** John Lewis KETCHAM

**14. MOTHER'S MAIDEN NAME:** Lilla McDONALD

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) YES (If Yes, give war or dates of service) WWI

**16. SOCIAL SECURITY NO.:** UNKNOWN

**17. INFORMANT & ADDRESS:** Wife: Mrs. Hannan S. KETCHAM - Same as 2 above

**18. MEDICAL CERTIFICATION**

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Coronary Insufficiency — 30 min.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. 420.1
DUE TO (b) Left and Right ventricular Hypertrophy — 5 years
DUE TO (c) Emphysema Pulmonary, Upper Lobes — 5 years

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:** **19b. MAJOR FINDINGS OF OPERATION** **20. AUTOPSY?** Yes ☒ No ☐

**21.** ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-9- ,1952 , to 1-19- ., 19 53, that I last saw the deceased alive on 1-19-, 1953 , and that death occurred at 6:06 PM , from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Albert E. Marland, Jr. M (MC) USN U.S. Naval Hospital, Bethesda, Md. 1-[illegible]-53

**23. BURIAL, CREMATION, REMOVAL** (Specify) [illegible]
DATE THEREOF 1-20-53
NAME OF CEMETERY OR CREMATORY Crown Hill
LOCATION (City, town, or county) Indianapolis (State) Indiana

DATE REC'D BY LOCAL REGISTRAR [illegible]-22-53
REGISTRAR'S SIGNATURE Elsie Cottingham
**24. FUNERAL DIRECTOR** S. H. H[illegible]S
ADDRESS 29[illegible] [illegible] Street, N.W. Washington, D. C.

JAN
PUBLIC U. S.

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH — COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Suburban Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda
STREET ADDRESS (If rural, give location): 4225 Glenford Road

3. NAME OF DECEASED (Type or Print): (First) Margaret (Middle) Anne (Last) Koelbel

4. DATE OF DEATH: (Month) Jan. (Day) 29 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Dec. 31, 1880

9. AGE last birthday: 72 yrs. If under 1 year: Months 0 Days 28 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Magdeburg, Germany

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Bauermeister

14. MOTHER'S MAIDEN NAME: Marie Opperman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Daughter - Mrs. Elmer K. Davis. 4225 Glenford Rd.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH —

Immediate cause (a) Coronary Thrombosis - with intra septal infarct Rupture of — Interval between onset and death: 36 hr.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Mesenteric Thrombosis + infarct of portion of intestine — 36 hr.
(c) Arteriosclerosis of aorta + Coronary vessels — 10 yr?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):
TIME OF INJURY (Month) (Day) (Year) (Hour):
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 28 Jan, 1953, to 29 Jan, 1953, that I last saw the deceased alive on 29 Jan, 1953, and that death occurred at 12: Noon m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
John S Bell M.D. 7936 Georgetown Rd Bethesda Md 29 Jan 53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial-transit
DATE THEREOF: 1/30/53
NAME OF CEMETERY OR CREMATORY: Woodlawn
LOCATION (City, town, or county) (State): Fayette Co. Iowa

DATE REC'D BY LOCAL REG.: 2/2/53
REGISTRAR'S SIGNATURE:
24. FUNERAL DIRECTOR: Robert A. Pumphrey
ADDRESS: Bethesda, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 11,606 Goodloe Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring; STREET ADDRESS (If rural, give location) 11,606 Goodloe Road

3. NAME OF DECEASED (Type or Print): (First) Stephen (Middle) Charles (Last) Kopp

4. DATE OF DEATH: (Month) Jan. (Day) 20 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: Dec. 9, 1952

9. AGE last birthday: yrs. If under 1 year: Months 1; Days 11; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Bethesda, Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Robert W. Kopp

14. MOTHER'S MAIDEN NAME: Geraldine C. Heck

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Mr. Robert W. Kopp, 11,606 Goodloe Road Silver Spring, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Asphyxia due to Vomitus — Interval between onset and death: 1 hour

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ; (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes [X] No [ ]

21. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at work [ ] Not while at work [ ] HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ] thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ] accident [X], suicide [ ], homicide [ ], undetermined [ ].*

SIGNATURE: Frank J. Bouchart (Degree or title) M.D. ADDRESS: Gaithersburg Md DATE SIGNED: 1-20-53

23. BURIAL, CREMATION OR REMOVAL (Specify): Burial DATE THEREOF: 1/21/53 NAME OF CEMETERY OR CREMATORY: St. John's Cemetery LOCATION (City, town, or county) (State): Montgomery County, Maryland

DATE REC'D BY LOCAL REG. 1/21/53 REGISTRAR'S SIGNATURE: [illegible] 24. FUNERAL DIRECTOR: Clarence E. Turner ADDRESS: 8434 Georgia Ave. Silver Spring, Md.

21 V 343402

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 7-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
LENGTH OF STAY (in this place) 20½ hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
STREET ADDRESS (If rural, give location) 1403 Wheaton Lane

3. NAME OF DECEASED (Type or Print): (First) Isabelle (Middle) (Last) Lomax
4. DATE OF DEATH (Month) 1 (Day) 14 (Year) 1953

5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH: 10-26-02
9. AGE last birthday: 50 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic - Day Work - Cleaning
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Charles Magruder
14. MOTHER'S MAIDEN NAME: Cecelia Gaither

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS: Husband - Eugene Lomax

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: 17 hours.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Hypertension arterial
(c) Atherosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/13, 19.53, to 1/14, 19.53, that I last saw the deceased alive on 1/14, 19.53, and that death occurred at 7:25 a.m., from the causes and on the date stated above.

SIGNATURE: Alfred S. Norton (Degree or title) M.D. ADDRESS 4711 Highland Ave DATE SIGNED 1/14/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 1/17/53
NAME OF CEMETERY OR CREMATORY: Allens Chapel
LOCATION (City, town, or county) (State): Wheaton, Md

DATE REC'D BY LOCAL REG.: 1/19/53
REGISTRAR'S SIGNATURE
24. FUNERAL DIRECTOR: Robert L. Snowden ADDRESS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write OR and give nearest town) OR TOWN Bethesda | RURAL | LENGTH OF STAY (in this place) 29 hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE Maryland — COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring, Md.
STREET ADDRESS (If rural give location) 9324 Ocala St.

**3. NAME OF DECEASED:** (Type or Print) (First) Lewis (Middle) (Last) MacKenzie

**4. DATE OF DEATH:** (Month) Jan. (Day) 5 (Year) 1953

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE Last birthday | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | married | 11-4-1892 | 60 yrs. | | |

**10a. USUAL OCCUPATION** Give kind of work done during most of working life, even if retired): Salesman-Surgical
**10b. KIND OF BUSINESS OR INDUSTRY:**
**11. BIRTHPLACE** (State or foreign country): Isle of Lewis (Scotland)
**12. CITIZEN OF WHAT COUNTRY?** No

**13. FATHER'S NAME:** Murdo MacKenzie
**14. MOTHER'S MAIDEN NAME:** Georgenia MacKenzie

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) (If Yes, give war or dates of service) No
**16. SOCIAL SECURITY NO.:**
**17. INFORMANT & ADDRESS** (Wife) Mrs. Mildred MacKenz... 9324 Ocala St. Silver Spring, Md.

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

022 X
Immediate cause (a) Ruptured Aneurysm - abdominal — 2-6 years
DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b)
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:** **19b. MAJOR FINDINGS OF OPERATION** **20. AUTOPSY?** Yes ☐ No ☒

**21.** ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 31 Dec., 1952, to 5 Jan., 1953, that I last saw the deceased alive on 4 Jan., 1953, and that death occurred at 9.30 a.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Edward L. Wilson Jr. | M.D. | 1801 - Eye St. N.W. | 5 Jan 53 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or County) (State) |
|---|---|---|---|
| Cremation | 1/8/53 | Ft. Lincoln Crematory | Prince George County, Md. |

DATE REC'D BY LOCAL REGISTRAR 1/9/53 — REGISTRAR'S SIGNATURE

**24. FUNERAL DIRECTOR** — ADDRESS
Warner L. Pumphrey — 8434 Ga. Ave., Silver Spring, Md.

V. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY [illegible] MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN [illegible] (RURAL) | LENGTH OF STAY (in this place) 20 Da.
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. NAVAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE [illegible] COUNTY [illegible]
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN [illegible]
STREET ADDRESS (If rural, give location) U.S. Naval Medical and Dental Station

| 3. NAME OF DECEASED (Type or Print) | (First) | (Middle) | (Last) | 4. DATE OF DEATH | (Month) | (Day) | (Year) |
|---|---|---|---|---|---|---|---|
| | Troy | Luther | MANESS | | January | 10, | 19[illegible] |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| MALE | WHITE | MARRIED | 8-16-14 | 38 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Petty Officer | U.S. Navy | NORTH CAROLINA | U. S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| UNKNOWN | Emeulal Stevens |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|---|
| YES | WWII | UNKNOWN | wife: Anna Edna Maness - [illegible] |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Cerebral hemorrhage | 10 days |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Small linear fracture petrous portion L. temporal bone

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☒ No ☐ |

| 21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY highway | (CITY OR TOWN) near Popular Spgs. Rt. #240 | (COUNTY) Howard | (STATE) md |
|---|---|---|---|---|

| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at work ☐ Not while at work ☒ | HOW DID INJURY OCCUR? |
|---|---|---|
| December 31, 1952 m. 5:50 PM | | auto accident |

22. *I certify that I took charge of the remains described above, held an Autopsy [X] Inspection [ ], Inquiry [ ] thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ] accident [X], suicide [ ], homicide [ ], undetermined [ ].*

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Frank J. Bourbeau | M.D. | Gaithersburg md | 1-11-53 |

| 23. BURIAL, CREMATION (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Removal | 1-12-53 | Arlington National | Arlington | Va. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 1-[illegible]-53 | Enid Whittington | R. A. PUMPHREY | 7557 Wisconsin Ave., Bethesda, Maryland |

JAN 13

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 516

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda — LENGTH OF STAY (in this place) 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Montgomery Hospital 8600 Old Georgetown Rd

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda 14
STREET ADDRESS (If rural give location) R.F.D. #3 Box 151

3. NAME OF DECEASED: (Type or Print) (First) Frank (Middle) G. (Last) Marsden Jr.

4. DATE OF DEATH: (Month) 1 (Day) 5 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: May 20 1885

9. AGE last birthday: 67 yrs. IF UNDER 1 YEAR: Months 7 Days 15 IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Retired

10b. KIND OF BUSINESS OR INDUSTRY: Carpenter-Gov.

11. BIRTHPLACE (State or foreign country): Maryland.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Franklin J. Marsden

14. MOTHER'S MAIDEN NAME: LAVINIA HINTON

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No.

16. SOCIAL SECURITY NO.: 578-36-0138

17. INFORMANT & ADDRESS: (Son) Mr Robert B Marsden R.F.D. #3 Box 151 Bethesda, Md.

## 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4

Immediate cause (a) Coronary occlusion — Interval Between Onset And Death: 1 day

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Chronic cardio-vascular-renal degeneration — 3 years.
DUE TO (c)

11 OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (Specify): PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/31, 1952, to 1/5, 1953, that I last saw the deceased alive on 1/5, 1953, and that death occurred at 5:30 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Ernest G. Bauersfeld M.D. ADDRESS Bethesda, Md. DATE SIGNED Jan. 5, 1953.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF Jan. 8, 1953 — NAME OF CEMETERY OR CREMATORY Potomac Methodist — LOCATION (City, town, or county) (State) Potomac, Montg. Co. Md.

DATE REC'D BY LOCAL REGISTRAR 1/7/53 — REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR ADDRESS Robert A. Pumphrey Bethesda, Md.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 9200 Second Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
STREET ADDRESS (If rural, give location) 9200 Second Avenue

3. NAME OF DECEASED (Type or Print): (First) RONALD (Middle) L. (Last) McDONALD

4. DATE OF DEATH: (Month) Jan. (Day) 31 (Year) 1953

5. SEX: Male (MALE) — 6. COLOR OR RACE: White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married — 8. DATE OF BIRTH: 4/22/95 — 9. AGE last birthday: 57 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Asst. Secty of Maritime Commission
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: George M. McDonald
14. MOTHER'S MAIDEN NAME: Susan E. Dailey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) WW #1
16. SOCIAL SECURITY NO.: none
17. INFORMANT AND ADDRESS: Mrs. Ruth K. McDonald, 9200 Second Ave. Silver Spring, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Ventricular Flutter — Interval between onset and death: 30 Min.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Advanced Emphysema of Lungs — 7-8 years.

(c)

527.1

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 15, 1952, to 31 Jan., 1953, that I last saw the deceased alive on 27 Jan., 1953, and that death occurred at 12 05 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

G. B. Cullen M.D. 7112 Willow Ave. Takoma Park Md. 31 Jan 1953.

23. BURIAL, CREMATION / REMOVAL (Specify): Burial
DATE THEREOF: 2/3/53
NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
LOCATION (City, town, or county) (State): Arlington County, Va.

DATE REC'D BY LOCAL REG.: 2/3/53
REGISTRAR'S SIGNATURE: Frances Potter
24. FUNERAL DIRECTOR: Warner & Dumphrey
ADDRESS: 8434 Georgia Ave. Silver Spring, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 1533 West Falkland Lane

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Pennsylvania; COUNTY Allegheny; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pittsburgh; STREET ADDRESS (If rural, give location) 3854 Brighton Road ✓

3. NAME OF DECEASED (Type or Print): (First) GENEVIEVE (Middle) A. (Last) McDYER

4. DATE OF DEATH: (Month) January (Day) 11 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: June 22, 1894

9. AGE last birthday: 58 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Receptionist - Rectory

10b. KIND OF BUSINESS OR INDUSTRY: St. Cyril's Church

11. BIRTHPLACE (State or foreign country): Latrobe, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Michael McDyer

14. MOTHER'S MAIDEN NAME: Mary C. Boyle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs. Grace C. McDevitt, 1533 W. Falkland Lane

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

1754

Immediate cause (a) Carcinomatosis of lungs and liver — Interval Between Onset and Death: 3 yrs +

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Carcinoma left breast metastasing to lungs and liver — 3 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Abdominal Ascites due to (a) & (b)

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): —

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Dec 13, 1952, to Jan 11, 1953, that I last saw the deceased alive on Jan 11, 1953, and that death occurred at 3:45 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Stewart Selaff M.D. ADDRESS: 3921 Ingomar St. N.W. DATE SIGNED: 1-11-53

23. BURIAL, CREMATION, REMOVAL (Specify): Shipment & burial

DATE THEREOF: Jan. 12, 1953

NAME OF CEMETERY OR CREMATORY: St. Vincent's Cemetery

LOCATION (City, town, or county) (State): Latrobe, Westmoreland Co., Pa.

DATE REC'D BY LOCAL REG.: 1/12/53

REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR: Warman E. Pumphrey ADDRESS: Silver Spring, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 423-

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Montgomery; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Takoma Park; LENGTH OF STAY (In this place): 16 mo; HOSPITAL OR INSTITUTION OR STREET ADDRESS: 211 Manor Circle

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Monty; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Takoma Park; STREET ADDRESS (If rural, give location): 211 Manor Circle

3. NAME OF DECEASED (Type or Print): (First) Alexander (Middle) Baxter (Last) McPherson

4. DATE OF DEATH: (Month) Jan (Day) 13 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: 3-28-1875

9. AGE last birthday: 77 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired

10b. KIND OF BUSINESS OR INDUSTRY: upholstery

11. BIRTHPLACE (State or foreign country): N. C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Hugh McPherson

14. MOTHER'S MAIDEN NAME: Mary Bell Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY No.: 577-34-9817

17. INFORMANT AND ADDRESS: Virginia McPherson (wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary occlusion — Interval between onset and death: ½ hr.

420 \

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ; (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION; 19b. MAJOR FINDINGS OF OPERATION; 20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY; (CITY OR TOWN); (COUNTY); (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.; INJURY OCCURRED While at work ☐ Not while at work ☐; HOW DID INJURY OCCUR?

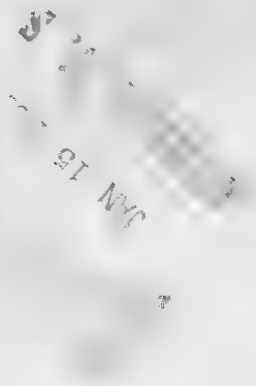
22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): Frank J. Bronhart M.D. ADDRESS: Gaithersburg md DATE SIGNED: 1-13-53

23. BURIAL, CREMATION REMOVAL (Specify): Burial; DATE THEREOF: Jan. 16-1953; NAME OF CEMETERY OR CREMATORY: Forest Lawn Cemetery; LOCATION (City, town, or county): Norfolk, (State): Virginia

DATE REC'D BY LOCAL REG.: Jan. 13 1953; REGISTRAR'S SIGNATURE: J. Milton Dodd

24. FUNERAL DIRECTOR: J. Arthur Walters, ADDRESS: 254 Carroll St. NW Takoma Park, DC



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville; LENGTH OF STAY (in this place) 13 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 500 W. Montgomery Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Illinois; COUNTY C
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chicago
STREET ADDRESS (If rural, give location) 6041 University Ave. ✓

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) Edward (Last) Merriam
4. DATE OF DEATH: (Month) 1 (Day) 8 (Year) 1953

5. SEX: Male
6. COLOR OR RACE: White-Cauc.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Nov 15 1874
9. AGE last birthday: 78 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): College Professor
10b. KIND OF BUSINESS OR INDUSTRY: Univ. of Chicago
11. BIRTHPLACE (State or foreign country): U.S.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Charles Edward Merriam
14. MOTHER'S MAIDEN NAME: Margaret Kirkwood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Mrs. Charles Merriam, wife, 6041 University Ave Chicago, Ill

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Apoplexy, repeated | 9 months |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Hypertension | 5 years |
| | (c) | |

3344

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Terminal hypostatic pneumonia 4 days and Uremia 7 days

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 22, 1952, to Jan 8, 1953, that I last saw the deceased alive on Jan 8, 1953, and that death occurred at 12:55 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Robert W. Gibson MD 500 W. Montgomery Ave, Rockville, Md 1/8/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 1-13-53
NAME OF CEMETERY OR CREMATORY: Arlington National
LOCATION (City, town, or county) (State): Arlington, Va.

DATE REC'D BY LOCAL REG. 1-26-53
REGISTRAR'S SIGNATURE: Helen S. Frenfelder per LVA.
24. FUNERAL DIRECTOR: Robert H. Humphreys
ADDRESS: Bethesda, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
MARYLAND
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
STREET ADDRESS (If rural give location) 4314 Lynton K DR

| 3. NAME OF DECEASED: (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH: (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Herman | Paul | Moeller | 1 | 24 | 1953 |

| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday: yrs. | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min. |
|---|---|---|---|---|---|---|
| Male | white | Married | 7/9/09 | 43 | | |

| 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Dental Mechanic | Dental Lab. | Germany | USA |

| 13. FATHER'S NAME: | 14. MOTHER'S MAIDEN NAME: |
|---|---|
| Herman J. Moeller | Anna Hambach |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: | 17. INFORMANT & ADDRESS: |
|---|---|---|
| Yes 1943 - 1946 | [illegible] | Wife, [illegible] |

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiac collapse with pulmonary edema

193+ Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO Glioma, left frontal lobe

(c)

Interval Between Onset And Death: 6 mos +

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION: Pneumoencephalogram attempted but not successful //

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-22, 1953, to 1-24, 1953, that I last saw the deceased alive on 1-23, 1953 and that death occurred at 1:15 P.M.; from the causes and on the date stated above.

| SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|
| Basilios J. Lambrou M.D. | 1832 K St. NW. | 1-24-53 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1-27-53 | Prospect Hill | Washington, D.C. |

| DATE REC'D BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 1/26/53 | [illegible] | Robert M. Umphrey | Bethesda, Md. |

Wt 1 lb 13 oz

26 to 28 weeks

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington
STREET ADDRESS (If rural, give location) 4017 - Decatur St.

3. NAME OF DECEASED (Type or Print) (First) MATTHEW (Middle) — (Last) Montee

4. DATE OF DEATH (Month) Jan (Day) 1 (Year) 1953

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH 12/31/52

9. AGE last birthday yrs. If under 1 year: Months / Days / If under 24 hrs.: Hours 16 / Min. 05

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Hobart Mansfield Montee

14. MOTHER'S MAIDEN NAME Katharine Marie Kennedy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS Hobart Montee father

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Immaturity

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 31, 1952 to Jan 1, 1953 that I last saw the deceased alive on Jan 1, 1953, and that death occurred at 10 10p m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John E. Cassidy M.D. 5402 Conn. Ave. Wash 1/1/53

23. BURIAL, CREMATION, REMOVAL (Specify) Removal & Burial

DATE THEREOF 1/3/53.

NAME OF CEMETERY OR CREMATORY Mt. Olivet

LOCATION (City, town, or county) Frederick (State) Md

DATE REC'D BY LOCAL REG. 1/5/53

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR Hart & Ellison ADDRESS Frederick Md

21 V2243270

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
ON 7 [illegible]
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Montgomery; MARYLAND
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Chevy Chase,
   LENGTH OF STAY (in this place):
   HOSPITAL OR INSTITUTION OR STREET ADDRESS: 105 West Woodbine St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Montgomery
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Chevy Chase
   STREET ADDRESS (If rural, give location): 105 West Woodbine St.

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) (Last) Moon

4. DATE OF DEATH: (Month) Jan (Day) 31 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: Feb. 19, 1885

9. AGE last birthday: 67 yrs. If under 1 year: Months 11, Days 12; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physicist

10b. KIND OF BUSINESS OR INDUSTRY: Nat. Bureau of Standards

11. BIRTHPLACE (State or foreign country): Pa.

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Cornelius Moon

14. MOTHER'S MAIDEN NAME: Ida Bell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
   (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Jennie S. Moon- Item # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420 1

Immediate cause (a) Coronary occlusion — Interval between onset and death: Sudden

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) [illegible] death

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
   PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:
   (CITY OR TOWN) (COUNTY) (STATE)
   TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
   INJURY OCCURRED While at work ☐ Not while at work ☐
   HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): Frank J. Bryant M.D. ADDRESS: Gaithersburg Md DATE SIGNED: 1-31-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit DATE THEREOF: Feb. 3, 1953 NAME OF CEMETERY OR CREMATORY: East Oak Grove LOCATION (City, town, or county) (State): Morgantown, West Virginia

DATE REC'D BY LOCAL REG. 2/2/53 REGISTRAR'S SIGNATURE: Bessie M. [illegible] 24. FUNERAL DIRECTOR: Robert A. Crumbley ADDRESS: Bethesda, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring — LENGTH OF STAY (in this place) — HOSPITAL OR INSTITUTION OR STREET ADDRESS 9201 Sudbury Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Montgomery — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring — STREET ADDRESS (If rural, give location) 9201 Sudbury Road

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| David | V. | Moore | Jan. | 29 | 1953 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | 12/10/86 | 66 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Merchant (retired) | Hardware | Iowa | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Benjamin J. Moore | Nellie Kellog |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY No. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| no | yes | Mr. Robert B. Moore, 9201 Sudbury Rd. Silver Spring, Md. |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary occlusion — several days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) [illegible] — due to

420.1 (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒ |
|---|---|---|
| | | |

| 21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Frank E. Boshart (Degree or title) M. D. ADDRESS Gaithersburg DATE SIGNED 1-29-53

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Trans. & Burial | 1/29/53 | Pleasant Hill Cemetery | Dunlap, Iowa |

| DATE REC'D BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 1/30/53 | [illegible] | Harvey L. Lundberg | 8134 Georgia Ave. Silver Spring, Md. |

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the figures of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 15 Princeton Ave.; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Glen Echo,

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 15 Princeton Ave.; STREET ADDRESS (If rural, give location) Glen Echo

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) INGRAM (Last) MOORE

4. DATE OF DEATH: (Month) (Day) (Year) Jan. 1, 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Sep. 13, 1865

9. AGE last birthday: 87 yrs. If under 1 year: Months 3, Days 18; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: Us

13. FATHER'S NAME: Richard Montgomery

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: 5421- 78th. St. H.M. Ingram - Bethesda, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Mesenteric Thrombosis — Interval Between Onset and Death: 72 hrs

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) —

(c) Generalized arterio-sclerosis — ?

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr 23, 1946, to Jan 1, 1953, that I last saw the deceased alive on Dec 29, 1952, and that death occurred at 8 Dec A m., from the causes and on the date stated above.

SIGNATURE: Malcolm A. Hamilton (Degree or title) M.D. ADDRESS 4535 Yuma St N.W. Wash. 16, D.C. DATE SIGNED 1/1/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 1/3/53

NAME OF CEMETERY OR CREMATORY: Samples Manor Church

LOCATION (City, town, or county) (State): Washington Co. Maryland

DATE REC'D BY LOCAL REG.:

REGISTRAR'S SIGNATURE:

24. FUNERAL DIRECTOR: Roberts & Pumphrey ADDRESS: Bethesda, Md.

RECEIVED
JAN 7 19
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. .

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
COUNTY MONTGOMERY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN (NRMC)
LENGTH OF STAY (in this place) D. [illegible]
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. NAVAL HOSPITAL

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE DISTRICT OF [illegible] COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN WASHINGTON, D. C.
STREET ADDRESS (If rural give location) 301[illegible] WILDER ST. N.W., D. C. ✓

**3. NAME OF DECEASED:** (Type or Print) (First) HUGH (Middle) L. (Last) MORRISON Jr.

**4. DATE OF DEATH:** (Month) January (Day) 8, (Year) 1953

| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | DIVORCED | 11-19-14 | 38 yrs. | | |

| 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| ELEVATOR OPERATOR | ---------- | NORTH CAROLINA | U.S. |

**13. FATHER'S NAME:** Hugh MORRISON

**14. MOTHER'S MAIDEN NAME:** Bessie WATTS

| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: | 17. INFORMANT & ADDRESS: |
|---|---|---|---|
| YES | WWII | UNKNOWN | Mother: Bessie Morrison-Same as above |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

490X

Immediate cause (a) Respiratory Failure — Interval Between Onset And Death: 2 Hrs.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Pneumonia, acute, all lobes due to beta type streptococcus — 7 days
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hepatic hypertrophy, fatty infiltration 6 mos.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-5-, 1953, to 1-8-, 1953, that I last saw the deceased alive on 1-8-, 1953, and that death occurred at 2:20 AM, from the causes and on the date stated above.

SIGNATURE Henry A. Sparks (Degree or title) ADDRESS USNH, NRMC, Bethesda, Maryland DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) moval DATE THEREOF 1-[illegible]-53 NAME OF CEMETERY OR CREMATORY Arlington National LOCATION (City, town, or county) Arlington (State) Va.

DATE REC'D BY LOCAL REGISTRAR REGISTRAR'S SIGNATURE Edith Whittington 24. FUNERAL DIRECTOR L. E. DAVIS ADDRESS [illegible], D. C.

VS. A15

JAN 1
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Jolliffes Home for Elderly Persons

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring; STREET ADDRESS (If rural, give location) 10,142 Dallas Ave.

| 3. NAME OF DECEASED (Type or Print) | (First) | (Middle) | (Last) | 4. DATE OF DEATH | (Month) | (Day) | (Year) |
|---|---|---|---|---|---|---|---|
| | George | M | Mueller | | Jan. | 29 | 1953 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Widowed | 3/18/73 | 79 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Molder | Foundry | Wisconsin | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John Mueller | Sabina (unknown) |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| no | yes | Mrs. Anita Pohlmann, 10142 Dallas Ave. Silver Spring, Md. |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Cerebral Vascular accident | 2 days |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Generalized arteriosclerosis | years |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☑ |

| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from 1-3, 1953 to 1-29, 1953, that I last saw the deceased alive on 1-22, 1953, and that death occurred at 6:50 a.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| [signature] | M.D. | 100 Lansing Rd. Silver Spring, Md. | Jan. 29, 1953 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Trans. & Burial | 1/30/53 | Greenwood Cemetery | Grand Rapids, Michigan |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 1/30/53 | | Simmons Funeral Home | 8434 Georgia Ave. Silver Spring, Maryland |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**PLACE OF DEATH:**

COUNTY [illegible] MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BETHESDA (RURAL)

LENGTH OF STAY (in this place) 1 Day 2 Hrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. NAVAL HOSPITAL

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

STATE MARYLAND COUNTY [illegible]

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BETHESDA

STREET ADDRESS (If rural give location) U. S. NAVAL HOSPITAL

| 3. NAME OF DECEASED: (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH: (Month) (Day) (Year) |
|---|---|---|---|
| Baby | Girl | NETTLETON | January 6, 19 53 |

| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| FEMALE | WHITE | SINGLE | 1-3-53 | 00 yrs. | | | | |

| 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| - - - - - - - | - - - - - - - - - | MARYLAND | U. S. |

| 13. FATHER'S NAME: | 14. MOTHER'S MAIDEN NAME: |
|---|---|
| Henry H. NETTLETON | Florence ANDERSON |

| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: | 17. INFORMANT & ADDRESS: |
|---|---|---|
| NO - - - - - | - - - - - | Father: Henry H. NETTLETON-1614 S Street, S[illegible], Washington, D.C. |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | Interval Between Onset And Death |
|---|---|---|---|
| Immediate cause | (a) | Congenital atelectasis | |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. | DUE TO (b) | Prematurity | 26 hrs. |
| | DUE TO (c) | | |

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☒ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from 1-7- ,19 53, to 1-8- ., 19 53, that I last saw the deceased alive on 1-8- , 19 53, and that death occurred at 2:10 PM ., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| [illegible] | | USNH, NNMC, Bethesda, Maryland | 1-[illegible]-53 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| [illegible] | 1-9-53 | NAVAL MEDICAL SCHOOL NNMC | BETHESDA MARYLAND |

| DATE REC'D BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| - - - | [illegible] | [illegible] MEDICAL CEN[illegible], BETHESDA, MD |

201322350

JAN 1
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A154

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2921 Tivoli Dr

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Monty
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
STREET ADDRESS (If rural, give location) 2921 Tivoli Dr.

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Beverly | Gail | Newman | Jan | 16 | 1953 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
|---|---|---|---|---|---|---|
| F | white | Single | 6-3-35 | 17 yrs. | | |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Washington DC
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Samuel E Newman
14. MOTHER'S MAIDEN NAME: Gladys Hecht

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT AND ADDRESS: S. E. Newman (Father)

18. MEDICAL CERTIFICATION

| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|
| Immediate cause (a) Carbon monoxide poisoning | Found dead in car |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) | |
| (c) | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | |

9-11

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Garage
(CITY OR TOWN) Silver Spring (COUNTY) Monty (STATE) Md
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR? Car in closed garage at home

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

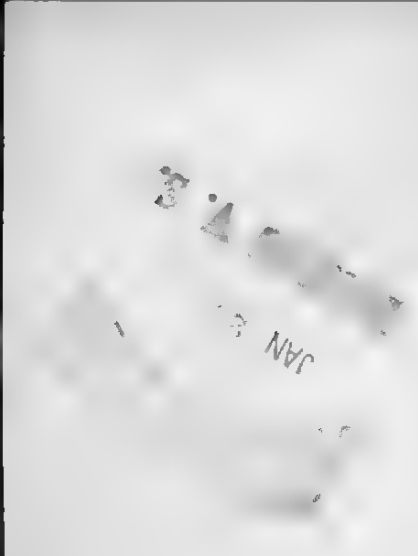
SIGNATURE: Frank J. Borchardt M.D. (Degree or title) ADDRESS: Gaithersburg Md DATE SIGNED: 1-16 53

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 1/16/53 | Elesavetgrad Cemetery | Washington DC |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 1-19 53 | Francis Potter | GOLDBERG FUNERAL HOME | 4217-9th NW Washington DC |

Burial 1/19/53

TA-9-4217



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 213

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN Rockville Md
LENGTH OF STAY (in this place) 30 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Olney Md R.F.D. 1
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (First) JAMES (Middle) MC CELLEN (Last) NICHOLSON
4. DATE OF DEATH: (Month) Jan (Day) 7 (Year) 1953
5. SEX: Male
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Dec 16 1870
9. AGE last birthday: 82 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter St Johns
10b. KIND OF BUSINESS OR INDUSTRY: Cemetery Olney Md
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Washington Nicholson
14. MOTHER'S MAIDEN NAME: Eliza Musgrove

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)
(If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 217-05-6873 219 05 6873
17. INFORMANT & ADDRESS: Bessie Nicholson Olney Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:
INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardio-respiratory failure / DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b) cerebral vascular accident (thrombosis) 30 min DUE TO
(c) generalized arteriosclerosis Indef.

331+

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/7/, 1953, to 1/7/, 1953, that I last saw the deceased alive on ....., 19....., and that death occurred at 8:30 A.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED
Stephen R. Jones M.D. Rockville Md 1/7/53

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF Jan 9 53
NAME OF CEMETERY OR CREMATORY St. Johns
LOCATION (City, town, or county) Olney Md (State)
DATE REC'D BY LOCAL REG. 1/28/53
REGISTRAR'S SIGNATURE Helen Chenfelder
24. FUNERAL DIRECTOR Roy W Barber Laytonsville ADDRESS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH:**
COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE Maryland — COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
STREET ADDRESS (If rural, give location) 1225 Centerhill Street

| 3. NAME OF DECEASED: (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH: (Month) (Day) (Year) |
|---|---|---|---|
| William | Hackett | Noone | Jan. 17 1953 |

| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min. |
|---|---|---|---|---|---|---|
| M | W. | Married | Aug 15 1880 | 72 yrs. | | |

| 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Miner | Coal. | West Virginia | USA. |

| 13. FATHER'S NAME: | 14. MOTHER'S MAIDEN NAME: |
|---|---|
| James Henry Noone | Ann Frances Hackett |

| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: | 17. INFORMANT & ADDRESS: |
|---|---|---|
| NO. | | James W. Noone 1225 Centerhill Street. |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Cancer of Lung — 1 yr.
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: 1. Silicosis of Lungs — 5 yr. 2. Cor Pulmonale — 1 yr.

| 19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from May, 1951, to Jan. 17, 1953, that I last saw the deceased alive on Jan. 17 1953 and that death occurred at 7.40 P.M., from the causes and on the date stated above.

| SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|
| Leo M. Curtis M.D. | 5707 Wisconsin Ave. Chevy Chase, Md. | Jan. 17, 1953 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) | ADDRESS |
|---|---|---|---|---|
| Burial | Jan 20 1953. | Parklawn | Rockville Pike Md | |

| DATE REC'D BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 1/19/53 | Bessie M. [illegible] | Chevy Chase Funeral Home | 5101 Wisconsin Ave NW DC |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 223

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH:**
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town: Takoma Park, Md.
LENGTH OF STAY (in this place): 10 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Washington Sanitarium Hosp.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE: Maryland — COUNTY: Montgomery
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
STREET ADDRESS (If rural give location): 566 Southampton Dr., S.S.

**3. NAME OF DECEASED:** (Type or Print) (First) Ruth (Middle) none (Last) Notton

**4. DATE OF DEATH:** (Month) 1 (Day) 4 (Year) 1953

**5. SEX:** Female

**6. COLOR OR RACE:** White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):** Widowed

**8. DATE OF BIRTH:** 3-4-1902

**9. AGE last birthday:** 46 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY:**

**11. BIRTHPLACE** (State or foreign country): New York

**12. CITIZEN OF WHAT COUNTRY?** U.S.A.

**13. FATHER'S NAME:** John Christian Baatz

**14. MOTHER'S MAIDEN NAME:** Freida Blum

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) No (If Yes, give war or dates of service)

**16. SOCIAL SECURITY NO.:**

**17. INFORMANT & ADDRESS:** Washington Sanitarium & Hospital Records

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between Onset And Death

Immediate cause (a) Post-operative Metastatic Carcinoma

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) of the breast with metastasis

DUE TO (c) to liver, bones & upper G.I. Tract — 8 to 12 months

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: May 3, 1952 Nov 3, 1953

19b. MAJOR FINDINGS OF OPERATION: Carcinoma of breast with metastasis to axilla Metastatic carcinoma of liver, stomach + upper intestines

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 8, 1952, to Jan 4, 1953, that I last saw the deceased alive on Jan 2, 1953, and that death occurred at 8:15 A.M., from the causes and on the date stated above.

SIGNATURE: Chas E. Jones (Degree or title) M.D. ADDRESS: 918 Ellsworth Drive, Silver Spring Md DATE SIGNED: Jan 4, 1953

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE THEREOF: 1-6-53 — NAME OF CEMETERY OR CREMATORY: Prospect Cemetery — LOCATION (City, town, or county) (State): Washington D.C.

DATE REC'D BY LOCAL REGISTRAR: Jan 7-1953 — REGISTRAR'S SIGNATURE: J. Hilton Dodd — 24. FUNERAL DIRECTOR — ADDRESS

RECEIVED
JAN 6
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; CITY OR TOWN Silver Spring; STATE MARYLAND; LENGTH OF STAY (in this place) 7 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS 7721 Eastman ave

2. USUAL RESIDENCE (HOME) OF DECEASED: COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring Md.; STREET ADDRESS (If rural, give location) 7721 - Eastman ave

3. NAME OF DECEASED (Type or Print): (First) Caroline (Middle) S (Last) Nussbaum

4. DATE OF DEATH: (Month) Jan. (Day) 20 (Year) 195-

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widow

8. DATE OF BIRTH: Nov 26 1856

9. AGE last birthday: 96 yrs. If under 1 year: Months, Days. If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Bastett Alsace France

12. CITIZEN OF WHAT COUNTRY? France

13. FATHER'S NAME: David Abel

14. MOTHER'S MAIDEN NAME: Sara Coulant Nathan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: -

17. INFORMANT AND ADDRESS: 7721 Eastman ave Charles H. Abel Silver Spring Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Termine of Congestive Heart Failure | 10 hrs. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Arterio - sclerotic Heart Disease | 10 yrs. |
| | (c) Senility | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-28, 1947, to 1-20, 1953, that I last saw the deceased alive on 1-19, 1953, and that death occurred at 12:35 A m., from the causes and on the date stated above.

SIGNATURE: Francis L Pickard (Degree or title) M.D. ADDRESS 7717 Alaska Ave N.W. Wash. D.C. DATE SIGNED 1-20-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE 1/22/53; NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery; LOCATION (City, town, or county): Washington; (State) DC

DATE REC'D BY LOCAL REG. 1/21/53; REGISTRAR'S SIGNATURE: Frances Fetter

24. FUNERAL DIRECTOR: H. Martin Wagner & Sons; ADDRESS 1310 N St NW Washington DC

I : 9: film G151 3-4-53 L

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

**1. PLACE OF DEATH**
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Kensington
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 3000 McComas Ave.

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: District of Columbia COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Washington
STREET ADDRESS (If rural, give location): 200 Douglas St., N.W. ✓

**3. NAME OF DECEASED** (Type or Print): (First) Louise (Middle) C. (Last) CULAHAN

**4. DATE OF DEATH**: (Month) Jan. (Day) 20 (Year) 1953

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED** (Specify): Widowed

**8. DATE OF BIRTH**: 9/4/74/ 76

**9. AGE** last birthday: 78 76 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Homemaker (retired)

**10b. KIND OF BUSINESS OR INDUSTRY**: Own home

**11. BIRTHPLACE** (State or foreign country): Washington, D. C.

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: John Graff

**14. MOTHER'S MAIDEN NAME**: Marie Joachin

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): no (If year, give war or dates of service):

**16. SOCIAL SECURITY NO.**: none

**17. INFORMANT AND ADDRESS**: Mr. John Shipman, 15 N. Highland St. Arlington, Virginia

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion Cardiac — Interval Between Onset and Death: 1 day

420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerosis, Cardiac Senes — years

(c) Senility — with Coronary Occlusion — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION**:

**19b. MAJOR FINDINGS OF OPERATION**:

**20. AUTOPSY?** Yes ☐ No ☐

**21. ACCIDENT SUICIDE HOMICIDE** (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour):

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

**22.** I hereby certify that I attended the deceased from 8/25/52, 19....., to 1/18/53, 19....., that I last saw the deceased alive on 1/18/53, 19....., and that death occurred at 1:00 A.m., from the causes and on the date stated above.

SIGNATURE: [signature] (Degree or title) MD ADDRESS: Kensington Md DATE SIGNED: 1/20/53

**23. BURIAL, CREMATION REMOVAL** (Specify): Burial — DATE: 1/22/53 — NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery — LOCATION (City, town, or county) (State): Washington, D. C.

DATE REC'D BY LOCAL REG. 1-23-53 — REGISTRAR'S SIGNATURE: [signature]

**24. FUNERAL DIRECTOR** ADDRESS: [signature] 8434 Georgia Ave. Silver Spring, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 249

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
   COUNTY: Montgomery — MARYLAND
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda, Rural
   LENGTH OF STAY (in this place): 2 days
   HOSPITAL OR INSTITUTION OR STREET ADDRESS: U. S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
   STATE: Virginia — COUNTY: Arlington
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Arlington
   STREET ADDRESS (If rural give location): 3001 S. 2nd Street ✓

3. NAME OF DECEASED: (First) Andrew (Middle) Billings (Last) PADDOCK

4. DATE OF DEATH: (Month) January (Day) 31 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: July 31, 1891

9. AGE last birthday: 61 yrs. IF UNDER 1 YEAR: Months 6 Days — IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Gov't Employee

10b. KIND OF BUSINESS OR INDUSTRY: Nat'l Prod Auth

11. BIRTHPLACE (State or foreign country): Nyack, New York

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Andrew Billings PADDOCK I

14. MOTHER'S MAIDEN NAME: Elizabeth HAVILAND

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Yes
    (If Yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 578-40-8684

17. INFORMANT & ADDRESS: Wife: Ingegerd A. PADDOCK, Same as Item #2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between Onset And Death

Immediate cause — (a) Hemorrhage, Cerebral — DUE TO

Antecedent causes (s) Diseases or conditions, If any, giving rise to the above cause stating the underlying cause last. — (b) Arteriosclerosis — DUE TO — (c)

331 ✗

1 week

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 29, 1953, to Jan. 31, 1953, that I last saw the deceased alive on Jan. 31, 1953, and that death occurred at 7:00 PM, from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

William E. CARTER, LTJG, MC, USNR — U. S. Naval Hospital, Bethesda, Md. — 2-1-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Feb. 3, 1953 — NAME OF CEMETERY OR CREMATORY: Arlington National — LOCATION (City, town, or county) (State): Arlington, Virginia

DATE RECD BY LOCAL REGISTRAR: Feb. 4, 1953 — REGISTRAR'S SIGNATURE: Edith Whittington

24. FUNERAL DIRECTOR — ADDRESS: Chambers Funeral Home, 1400 Chapin St., N. W., Washington, D. C.

FEB 3

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 217

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Olney; MARYLAND LENGTH OF STAY (In this place) U.S.A.; HOSPITAL OR INSTITUTION OR STREET ADDRESS Mont. Co. Gen. Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Mont; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cooksville; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Augustus (Middle) (Last) Parker

4. DATE OF DEATH: (Month) Jan (Day) 4 (Year) 1953

5. SEX: male

6. COLOR OR RACE: Col.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: April 8 1925

9. AGE last birthday: 27 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: U. S. S. Com.

11. BIRTHPLACE (State or foreign country): md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Winfield Parker

14. MOTHER'S MAIDEN NAME: Margaret E. Dorsey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) W.W II

16. SOCIAL SECURITY No.: 218-12-8878

17. INFORMANT AND ADDRESS: John W. Parker - Cooksville Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Hemorrhage due to severance

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) of left common carotid artery

(c)

INTERVAL BETWEEN ONSET AND DEATH: Few minutes

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Tavern

(CITY OR TOWN) Cooksville (COUNTY) Howard (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) Jan 3 53 - 11:45 P.M.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? Lacerated by ax. woman

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.*

SIGNATURE: Frank J. Brozenhart (Degree or title) M.D. ADDRESS: Gaithersburg Md DATE SIGNED: 1-4-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 1-7-53

NAME OF CEMETERY OR CREMATORY: Bushy Park

LOCATION (City, town, or county) (State): Cooksville, Howard Md.

DATE REC'D BY LOCAL REG.: Jan. 5, 1953

REGISTRAR'S SIGNATURE: Gertrude Lawler

24. FUNERAL DIRECTOR: Wilbur H. Haight & Luther A. Haight ADDRESS: Sykesville, Md.

...INT TO LO... ...DATE ...
JAN 6 ...
BUREAU V. S...

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 217

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the figures of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Olney
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Montg. Co. Gen. Hospt.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville
STREET ADDRESS (If rural, give location) 806 Grandin Ave.

3. NAME OF DECEASED (Type or Print): (First) ERNEST (Middle) H. (Last) PETERS

4. DATE OF DEATH: (Month) Jan. (Day) 16, (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Sept. 4, 1875

9. AGE last birthday: 77 yrs. If under 1 year: Months 4, Days 12; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Owner

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: John Peters

14. MOTHER'S MAIDEN NAME: Sarah Geisler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 579-22-0047-A

17. INFORMANT AND ADDRESS: Laura Peters- Item # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) CEREBRAL HEMORRHAGE | 14 HRS. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) POSSIBLE CARCINOMA OF STOMACH | 1 YEAR |
| | (c) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE | 15 YEARS |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JAN 10 1951, to NOV 5, 1952 that I last saw the deceased alive on JAN. 16, 1953, and that death occurred at 8:50 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Gordon S. Rasenberger M.D. Rockville, Md 1/19/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 1-19-53

NAME OF CEMETERY OR CREMATORY: Rockville Union

LOCATION (City, town, or county) (State): Rockville, Md.

DATE REC'D BY LOCAL REG.: 1-17-53

REGISTRAR'S SIGNATURE: Gertrude B Fawley

24. FUNERAL DIRECTOR: Robert A. Dunphey ADDRESS: Bethesda, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Spring
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 4415 Garrett Park Road

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Spring
STREET ADDRESS (If rural, give location): 4415 Garrett Park Road

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) Oscar (Last) Petrain

4. DATE OF DEATH: (Month) Jan. (Day) 24 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 3/12/82

9. AGE Last birthday: 70 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired U.S. Government Employee

10b. KIND OF BUSINESS OR INDUSTRY: Federal Security

11. BIRTHPLACE (State or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Olof Petrain

14. MOTHER'S MAIDEN NAME: Ellen Skogs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Mrs. Elizabeth C. Petrain, Silver Spring, Md. 4415 Garrett Pk., Rd.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Coronary occlusion | Instant |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Chronic hypertensive Heart Disease | 3 yrs |
| | (c) arteriosclerosis | 10 yrs |

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ✓, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: C. H. Bauerfeld M.D. — (Degree or title): Sr. Asst. Surgeon — ADDRESS: Bethesda, Md. — DATE SIGNED: 1/24/53

23. BURIAL, CREMATION, REMOVAL (Specify): Trans. & Burial — DATE THEREOF: 1/27/53 — NAME OF CEMETERY OR CREMATORY: Riverside Cemetery — LOCATION (City, town, or county) (State): Moline, Illinois

DATE REC'D BY LOCAL REG.: 1/27/53 — REGISTRAR'S SIGNATURE: Samuel [illegible]

24. FUNERAL DIRECTOR: Werner E. Turnbaugh — ADDRESS: 8434 Georgia Ave. Silver Spring, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

60683

Reg. Dist. No. 217

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH:**
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Olney
LENGTH OF STAY (in this place): 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: The Montgomery County General Hospital, Inc.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sandy Spring
STREET ADDRESS (If rural give location):

**3. NAME OF DECEASED:** (Type or Print) (First) Josephine (Middle) (Last) Powell

**4. DATE OF DEATH:** (Month) January (Day) 28 (Year) 1953

**5. SEX:** female

**6. COLOR OR RACE:** colored

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):** Married

**8. DATE OF BIRTH:** 2/22/1894

**9. AGE last birthday:** 58 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION.** Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY:**

**11. BIRTHPLACE** (State or foreign country): Maryland

**12. CITIZEN OF WHAT COUNTRY?** U.S.A.

**13. FATHER'S NAME:** Augustus Hackett

**14. MOTHER'S MAIDEN NAME:** Anna

**15. WAS DECEASED EVER IN U.S ARMED FORCES?** (Yes, no, or unk.) (If Yes, give war or dates of service)

**16. SOCIAL SECURITY No.:**

**17. INFORMANT & ADDRESS:** Hospital Records

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X

Immediate cause (a) Cerebro-vascular Accident (Hemorrhage) — Interval Between Onset And Death: 1 wk.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Hypertensive Cardio-Vascular Disease — 4 Yrs

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:** **19b. MAJOR FINDINGS OF OPERATION**

**20. AUTOPSY?** Yes ☐ No ☑

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..... 1951, to 1/28, 1953, that I last saw the deceased alive on 1/27, 1953, and that death occurred at 4:56 a.m. from the causes and on the date stated above.

SIGNATURE (Degree or title): [signature] M.D. — ADDRESS: Sandy Spring M.D. — DATE SIGNED: 1/28/53

**23. BURIAL, CREMATION, REMOVAL** (Specify): Burial — DATE THEREOF: 1/31/53 — NAME OF CEMETERY OR CREMATORY: Sandy Spring — LOCATION (City, town, or county) (State): Sandy Spring md

DATE REC'D BY LOCAL REGISTRAR: 1-31-53 — REGISTRAR'S SIGNATURE: Gertrude B Lawler

**24. FUNERAL DIRECTOR** — ADDRESS: Robt. S. Snowden Rockville Md

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 7-14

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Montgomery | MARYLAND | LENGTH OF STAY (in this place): 9 yrs
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Spring
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 10601 Sweetbriar Park

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland | COUNTY: Montg
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Spring
STREET ADDRESS (If rural, give location): 10601 Sweetbriar Park.

3. NAME OF DECEASED (Type or Print): (First) Margarete | (Middle) R | (Last) Purcell

4. DATE OF DEATH: (Month) Jan | (Day) 16 | (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 4-21-1875

9. AGE last birthday: 77 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: John Cantin

14. MOTHER'S MAIDEN NAME: Ella Frye

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no | (If yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT AND ADDRESS: Gertrude Boarman 10601 Sweetbriar Rd Silver Spring Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary occlusion — Interval Between Onset and Death: sudden death

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ____ (c) ____

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

Frank J Boarhart M.D. | Gaithersburg Md | 1-16-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: 1-19-53 | NAME OF CEMETERY OR CREMATORY: Cedar Hill | LOCATION (City, town, or county) (State): Suitland Md.

DATE REC'D BY LOCAL REG.: 1-16-53 | REGISTRAR'S SIGNATURE: Frances Potter | 24. FUNERAL DIRECTOR | ADDRESS: Neal Funeral Home 4812 Ga Ave Wash DC

VS. A154

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. ...

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH:**
COUNTY ...GOMERY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BETHESDA (RURAL)
LENGTH OF STAY (in this place): 22 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S. NAVAL HOSPITAL

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE DISTRICT OF COLUMBIA COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN WASHINGTON, D. C.
STREET ADDRESS (If rural give location): 5051 New Hampshire Avenue, N.W. ✓

**3. NAME OF DECEASED:** (Type or Print) (First) Harry (Middle) ...ober (Last) RATCLIFFE

**4. DATE OF DEATH:** (Month) January (Day) 21, (Year) 1953

| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | Sept. 23, 1878 | 74 yrs. | | | | |

| 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Architect | Veterans Administration | ILLINOIS | U.S. |

**13. FATHER'S NAME:** Edward David RATCLIFFE

**14. MOTHER'S MAIDEN NAME:** Margaret CAMERON

| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: | 17. INFORMANT & ADDRESS: |
|---|---|---|---|
| YES | SpAm | 577-44-0038 | wife. Mrs. Betty B. Ratcliffe, - Same as 2 above. |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset And Death |
|---|---|---|
| Immediate cause | (a) Congestive Heart Failure | 4 hours |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. | (b) DUE TO Hypertensive Cardiovascular Disease | 10+ years |
| | (c) DUE TO | |

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes X No ☐

21. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-30-, 1952, to 1-21-, 1953, that I last saw the deceased alive on 1-21, 1953, and that death occurred at 7:00 PM, from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| William Thomas Hall | M.D. USNH, NNMC., | Bethesda, Maryland | |

| 23. BURIAL, CREMATION, REMOVAL. (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | 1-26-53 | Arlington National | Arlington | Virginia |

| DATE REC'D BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| -2-53 | Fred Ketterington | Chambers | 1400 Chapin St., N.W. Washington, D. C. |

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 213

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Montgomery; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 315 Baltimore Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville; STREET ADDRESS (If rural, give location) 315 Baltimore Rd.

3. NAME OF DECEASED (Type or Print): (First) Barbara (Middle) Anola (Last) Ray

4. DATE OF DEATH: (Month) Jan. (Day) 9, (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: Oct. 4 1874

9. AGE last birthday: 78 yrs. If under 1 year: Months 3; Days 5; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Eleazer Ray

14. MOTHER'S MAIDEN NAME: Eliza Erb

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Russell Bogley 728 Virginia Ave Rockville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause (a) | Coronary occlusion | 1 hour |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) | arteriosclerosis, coronary sclerosis | 3 years |
| (c) | | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1945, 19..., to Jan. 9, 1953 that I last saw the deceased alive on Jan. 9, 1953 and that death occurred at 5 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Wm. A. Linthicum, M.D. Rockville, Md. 1/9/53.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 1-12-53

NAME OF CEMETERY OR CREMATORY: Rockville Union

LOCATION (City, town, or county) (State): Rockville, Md

DATE REC'D BY LOCAL REG. 1-28-53

REGISTRAR'S SIGNATURE: H. J. Eckenfelder

24. FUNERAL DIRECTOR: Robt. A. Dunphey

ADDRESS: Bethesda, Md.

Per L.V.A.

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 223

1. PLACE OF DEATH: COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Takoma Park
LENGTH OF STAY (In this place): 2 hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Washington Sanitarium & Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Spring
STREET ADDRESS (If rural, give location): 2015 Lanier Drive

3. NAME OF DECEASED (Type or Print): (First) ROBERT (Middle) STANLEY (Last) RAY

4. DATE OF DEATH: (Month) January (Day) 4 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: Aug. 25, 1928

9. AGE last birthday: 24 yrs. — If under 1 year: Months / Days — If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk in Montgomery County Sheriff's Office

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Florida

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: L. S. Ray

14. MOTHER'S MAIDEN NAME: Julia LeHardy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 578-34-4980

17. INFORMANT AND ADDRESS: L. S. Ray, 2015 Lanier Dr., Silver Spring, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Extra-dural hemorrhage due to — 2 hrs

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) fracture of skull

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: street — (CITY OR TOWN): Silver Spring — (COUNTY): Montgomery — (STATE): Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): 1/4/53 7:10 A. m. — INJURY OCCURRED While at work ☐ Not while at work ☒ — HOW DID INJURY OCCUR? Auto accident

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: Frank J. Bauernhart — (Degree or title): M. D. — ADDRESS: Gaithersburg, Md. — DATE SIGNED: 1-4-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Jan. 6, 1953 — NAME OF CEMETERY OR CREMATORY: St. Mark's Epis. Cemetery — LOCATION (City, town, or county) (State): Fairland, Montg. Co., Md.

DATE REC'D BY LOCAL REG.: Jan 7-1953 — REGISTRAR'S SIGNATURE: J. Wilson Dodd

24. FUNERAL DIRECTOR — ADDRESS: Warner C. Pumphrey, Silver Spring, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V.S. Al

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 223

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park; LENGTH OF STAY (in this place) 20 min; HOSPITAL OR INSTITUTION OR STREET ADDRESS Wash. San. and Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montg.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hyattsville; STREET ADDRESS (If rural, give location) 8622 New Hyatt Rd ✓

3. NAME OF DECEASED (Type or Print): (First) Bessie (Middle) Ellen (Last) Resley

4. DATE OF DEATH: (Month) 1 (Day) 4 (Year) 53

5. SEX: Female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: 11-24-83

9. AGE last birthday: 69 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): LIMA, Ohio

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN G. BELL.

14. MOTHER'S MAIDEN NAME: EVA SUNDERLAND

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or date of service)

16. SOCIAL SECURITY No. none

17. INFORMANT AND ADDRESS: Hosp Record

### 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

**Immediate cause** (a) Coronary occlusion — 1 hr.

**Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ____ (c) ____

42cc)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Frank A. Bouchard M.D. Gaithersburg Md 1-4-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF 1/7/1953 | NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY | LOCATION (City, town, or county) SUITLAND P.G. Co. Md (State)

DATE REC'D BY LOCAL REG. 1/6 1953 | REGISTRAR'S SIGNATURE J. Victor Rock | 24. FUNERAL DIRECTOR W.W. Chambers Co ADDRESS Riverdale

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda
LENGTH OF STAY (in this place): 11 hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Suburban Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE: Maryland — COUNTY: Montg.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Potomac
STREET ADDRESS (If rural give location):

**3. NAME OF DECEASED:** (Type or Print) (First) John (Middle) Thomas (Last) Ricketts

**4. DATE OF DEATH:** (Month) Jan. (Day) 27 (Year) 1953

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | married | Dec. 20, 1876 | 76 yrs. | 2 | 7 | | |

| 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | Montg.Co. Govt. | Potomac, Maryland | USA |

**13. FATHER'S NAME:** Edward Ricketts

**14. MOTHER'S MAIDEN NAME:** Unknown

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: | 17. INFORMANT & ADDRESS: |
|---|---|---|
| No | None | Rudolph Ricketts - Same Item #2 |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) 471X Bronchopneumonia — Interval Between Onset And Death: 3-4 days.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Chronic bronchitis, chronic myocarditis 3 years

| 19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | Yes ☐ No ☑ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

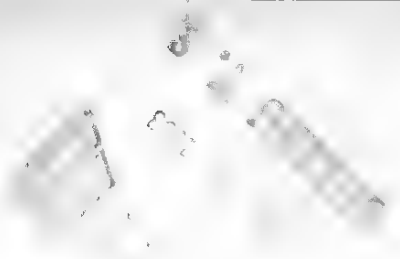
22. I hereby certify that I attended the deceased from 1948, to Jan. 27, 1953, that I last saw the deceased alive on Jan. 27, 1953, and that death occurred at 7:40 A.M., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Wm. A. Leatherwood | M.D. | Rockville, Md. | 1/27/53 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1/31/53 | Forest Oak | Gaithersburg Maryland |

| DATE REC'D BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 1/28/53 | Bessie M. Thompson | Robert A. Pumphrey | Bethesda, Md. |

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
COUNTY Montgomery MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS (If not in hospital or institution, give street address or location) JOLLIFF'S NURSING HOME

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE D. of C. COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington
STREET ADDRESS (If rural give location) 4217 INGOMAR ST NW

**3. NAME OF DECEASED:** (Type or Print) (First) PETER (Middle) SACHARIS (Last) Sacharis

**4. DATE OF DEATH:** (Month) Jan. (Day) 29 (Year) 1953

**5. SEX:** M

**6. COLOR OR RACE:** W

**7. SINGLE, MARRIED, WIDOWED, DIVORCED,** (Specify): W

**8. DATE OF BIRTH:** JUNE 15 1858

**9. AGE** last birthday: 94 yrs. If UNDER 1 YEAR Months Days; If UNDER 24 HRS. Hours Min.

**10a. USUAL OCCUPATION.** Give kind of work done during most of working life, even if retired): RET - Tobacco Factory

**10b. KIND OF BUSINESS OR INDUSTRY:**

**11. BIRTHPLACE** (State or foreign country): GREECE Empire

**12. CITIZEN OF WHAT COUNTRY?** Greece

**13. FATHER'S NAME:** GEORGE

**14. MOTHER'S MAIDEN NAME:** unknown

**15 WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) No (If Yes, give war or dates of service)

**16. SOCIAL SECURITY NO.:**

**17. INFORMANT & ADDRESS:** SANITARIUM Rockville

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

1/17 Immediate cause (a) Cerebral metastasis of Carcinoma of Lung — 2 mo.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Carcinoma of Lung — 6 mo.

DUE TO (c) Carcinoma of parotid — 1 yr.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Generalized arteriosclerosis — Years

**19a. DATE OF OPERATION:** **19b. MAJOR FINDINGS OF OPERATION**

**20. AUTOPSY?** Yes ☐ No ☑

**21.** ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 25, 1952 to Jan 29, 1953 that I last saw the deceased alive on Jan 27, 1953 and that death occurred at 4:40 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
1009 Lamberg Rd. Silver Spring, Md. Jan 29, 1953

**23. BURIAL, CREMATION, REMOVAL** (Specify) DATE THEREOF JAN 31, 1953 NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REGISTRAR 1-30-53 REGISTRAR'S SIGNATURE Samuel Potter

**24. FUNERAL DIRECTOR** ADDRESS

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. ...

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1 PLACE OF DEATH: COUNTY [illegible] MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN [illegible] (RURAL) LENGTH OF STAY (in this place) Approx. 5 Hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. NAVAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE [illegible] COUNTY [illegible]
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SILVER SPRING
STREET ADDRESS (If rural give location) 10112 KINROSS STREET

3. NAME OF DECEASED: (Type or Print) (First) Herbert (Middle) John (Last) SAYER III

4. DATE OF DEATH: (Month) January (Day) 14, (Year) 19 53

5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single | 8. DATE OF BIRTH: 2-9-50 | 9. AGE last birthday: 2 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): - - - - - | 10b. KIND OF BUSINESS OR INDUSTRY: - - - - - - - | 11. BIRTHPLACE (State or foreign country): BETHESDA, MARYLAND | 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Herbert John SAYER

14. MOTHER'S MAIDEN NAME: Josephine DESIDERIO

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NC | (If Yes, give war or dates of service) - - - - | 16 SOCIAL SECURITY No.: NONE | 17. INFORMANT & ADDRESS: Father: Herbert John SAYER - Same as 2 above

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) ... Circulatory Collapse DUE TO ... Interval Between Onset And Death 4-6 hrs.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) ... Cerebral Edema DUE TO ... unknown

(c) undetermined ... "

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-14, 1953, to 1-14-, 1953, that I last saw the deceased alive on 1-14, 1953, and that death occurred at 11:45 PM, from the causes and on the date stated above.

SIGNATURE [signature] (Degree or title) ADDRESS USNH, Bethesda, Md. DATE SIGNED 1-15-53

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF 1-15-53 | NAME OF CEMETERY OR CREMATORY Arlington National | LOCATION (City, town, or county) Arlington (State) Virginia

DATE REC'D BY LOCAL REGISTRAR 1-15-53 | REGISTRAR'S SIGNATURE [signature] | 24. FUNERAL DIRECTOR CHAMBERS | ADDRESS 14th & C and St., N.W. Washington, D. C.

JAN 16
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A1 -51

**1. PLACE OF DEATH:**
COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
LENGTH OF STAY (in this place) 4 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1605 Oakview Drive

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE New York COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Wantagh, Long Island
STREET ADDRESS 1815 Excell Drive (If rural, give location) ✓

**3. NAME OF DECEASED: (Type or Print)** (First) DANIEL (Middle) — (Last) SCHOLTZ

**4. DATE OF DEATH:** (Month) January (Day) 19 (Year) 19 53

**5. SEX:** MALE

**6. COLOR OR RACE:** White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):** MARRIED

**8. DATE OF BIRTH:** July 11, 1886

**9. AGE last birthday:** 66 yrs. IF UNDER 1 YEAR Months 6 Days 8 IF UNDER 24 HRS. Hours Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): PAINTER

**10b. KIND OF BUSINESS OR INDUSTRY:** Ralston Co.

**11. BIRTHPLACE** (State or foreign country): AMSTERDAM, HOLLAND

**12. CITIZEN OF WHAT COUNTRY?** U. S. A.

**13. FATHER'S NAME:** DANIEL SCHOLTZ SR.

**14. MOTHER'S MAIDEN NAME:** MARIA PRINCE

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) NO (If Yes, give war or dates of service)

**16. SOCIAL SECURITY NO.:** 051-09-7682

**17. INFORMANT & ADDRESS:** CHARA SCHOLTZ — 1605 OAK VIEW DR. - WIFE

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Carcinoma of Lung & Metastases | |
| | DUE TO | |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last | (b) | |
| | DUE TO | |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis.

**19a. DATE OF OPERATION:** Feb 1950

**19b. MAJOR FINDINGS OF OPERATION:** Carcinoma left lung

**20. AUTOPSY?** Yes ☐ No ☐

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1952, to January 19 53, that I last saw the deceased alive on Jan 15, 19 53, and that death occurred at 2:00 A m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) Bernard A. FitzGerald MD ADDRESS 9620 Old Bladensburg Rd, S.S. DATE SIGNED 1/19/53

**23. BURIAL, CREMATION REMOVAL (Specify):** Burial

DATE THEREOF 1/21/53

NAME OF CEMETERY OR CREMATORY Geo. Wash. Mem. Cemetery

LOCATION (City, town, or county) (State) Prince George County, Md.

DATE REC'D BY LOCAL REG. 1/21/53

REGISTRAR'S SIGNATURE Frances Potter

**24. FUNERAL DIRECTOR** Warner E. Pumphrey ADDRESS 8434 Georgia Ave. Silver Spring, Md.

JAN 23 1923

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington Sanitarium
LENGTH OF STAY (in this place) 2 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Takoma Park, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Wash. COUNTY D. C.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN [illegible]
STREET ADDRESS (If rural, give location) 2110 [illegible] St. N.E. ✓

3. NAME OF DECEASED (Type or Print) (First) Ellen (Middle) Gertrude (Last) Seabrook
4. DATE OF DEATH (Month) 1 (Day) 4 (Year) 1953

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Mo. 12 Day 22 Year 1863
9. AGE last birthday 89 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Hillsborough Co. Ireland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME [illegible]
14. MOTHER'S MAIDEN NAME Mary Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Mrs. Walter Lowe, Takoma Park, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Arteriosclerotic cardiovascular disease | 20 yrs. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Bronchial asthma. | 10 yrs. |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/2/52* 19*, to 1/1 19 53, that I last saw the deceased alive on 1/4/53, 19, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

SIGNATURE James P. Kerr (Degree or title) M.D. ADDRESS Damascus, Md. DATE SIGNED 1/6/53

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF Jan. 8 53 | NAME OF CEMETERY OR CREMATORY Hillandale | LOCATION (City, town, or county) Highland (State) Md.

DATE REC'D BY LOCAL REG. Jan. 5, 1953 | REGISTRAR'S SIGNATURE Glenda L. Cook | 24. FUNERAL DIRECTOR Robert C. Hemphill | ADDRESS Takoma Park, Md.

RECEIVED

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Written permission received from both parents.

VS. A15

**1. PLACE OF DEATH:**
COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Sanitarium & Hospital, Takoma Park Md

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE Maryland — COUNTY Prince George
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park, Md.
STREET ADDRESS (If rural give location) 1100 Linden Ave.

**3. NAME OF DECEASED:** (Type or Print) (First) Infant (Middle) (Last) Scott

**4. DATE OF DEATH:** (Month) January (Day) 2 (Year) 1953

**5. SEX:** Female

**6. COLOR OR RACE:** White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):** —

**8. DATE OF BIRTH:** 1-2-53

**9. AGE last birthday:** — yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. 46

**10a. USUAL OCCUPATION** Give kind of work done during most of working life, even if retired): —

**10b. KIND OF BUSINESS OR INDUSTRY:** —

**11. BIRTHPLACE** (State or foreign country): Md.?

**12. CITIZEN OF WHAT COUNTRY?**

**13. FATHER'S NAME:** John Raymond Scott Jr.

**14. MOTHER'S MAIDEN NAME:** Evan Virginia Rowell

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) (If Yes, give war or dates of service)

**16. SOCIAL SECURITY NO.:**

**17. INFORMANT & ADDRESS:** Hospital Records.

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Asphyxiation — Interval Between Onset And Death: 45 min

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Premature with Malformation

DUE TO (c)

II OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:** **19b. MAJOR FINDINGS OF OPERATION** **20. AUTOPSY?** Yes ☐ No ☐

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-2 ..., 1953, to 1-2, 1953, that I last saw the deceased alive on 1-2, 1953, and that death occurred at 10:45 P.M., from the causes and on the date stated above.

SIGNATURE N. Lewis (Degree or title) M.D. ADDRESS 9601 Georgia Ave Silver Spring Md DATE SIGNED 1/2/53

**23. BURIAL, CREMATION, REMOVAL** (Specify) cremation — DATE THEREOF 1-6-53 — NAME OF CEMETERY OR CREMATORY Wash., San., & Hospital — LOCATION (City, town, or county) Takoma Park, Maryland (State)

DATE REC'D BY LOCAL REGISTRAR Jan 5 1953 — REGISTRAR'S SIGNATURE [illegible]

**24. FUNERAL DIRECTOR** Robert A. Hare, M.D. Takoma Park, Md. ADDRESS

201322 1953

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
LENGTH OF STAY (In this place) 9 weeks
HOSPITAL OR INSTITUTION OR STREET ADDRESS 517 Albany Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Col. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (Rural give location) 422 Butternut St. N.W. ✓

3. NAME OF DECEASED (Type or Print): (First) Mae (Middle) S. (Last) Searle

4. DATE OF DEATH: (Month) Jan. (Day) 5 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Oct. 29 1866

9. AGE last birthday: 86 yrs. If under 1 year: Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Washington D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles K. Shryock

14. MOTHER'S MAIDEN NAME: Harriet Fravel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.

17. INFORMANT: William T. Stephens 505 Washington Bldg. Washington 5, D.C.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Coronary Thrombosis | 30 min. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Arteriosclerotic Heart Disease | 3 Mo. + |
| | (c) Generalized Arteriosclerosis | Years |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | Hiatus hernia | 3 mo. + |

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 5, 1953, to Jan. 5, 1953, that I last saw the deceased alive on Jan. 5, 1953, and that death occurred at 4:51 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

William R. Mook M.D. 7701 Carroll Ave. Takoma Pk. Md. 1-5-53

23. BURIAL, CREMATION, REMOVAL (Specify) DATE: Jan-8-1953 NAME OF CEMETERY OR CREMATORY: Arlington Natl. Cem LOCATION (City, town, or county) (State): Arlington Va

DATE REC'D BY LOCAL REG. Jan 5 1953 REGISTRAR'S SIGNATURE J. Walter Dodd

24. FUNERAL DIRECTOR ADDRESS: Martin W Hysong Co 1800 N Ht Nw. Wash D.C.

RECEIVED
JAN 7 19..
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 -51

**1. PLACE OF DEATH:**

COUNTY MONTGOMERY. MARYLAND

CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) BETHESDA, MARYLAND. LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS SUBURBAN HOSPITAL BETHESDA, MARYLAND.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

STATE MD. COUNTY MONTGOMERY.

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 212 E. FRANKLIN ST.

STREET ADDRESS (If rural, give location) SILVER SPRING, MARYLAND.

**3. NAME OF DECEASED: (Type or Print)** (First) CARL (Middle) — (Last) SEARS

**4. DATE OF DEATH:** (Month) JAN. (Day) 21 (Year) 19 53

**5. SEX:** MALE

**6. COLOR OR RACE:** WHITE

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):** MARRIED.

**8. DATE OF BIRTH:** NOV. 25, 1896

**9. AGE last birthday:** 56 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): CHIEF DEPT. CONTROLS

**10b. KIND OF BUSINESS OR INDUSTRY:** GOVT. SERVICE

**11. BIRTHPLACE** (State or foreign country): INDIANA

**12. CITIZEN OF WHAT COUNTRY?** U.S.

**13. FATHER'S NAME:** Isaac JACKSON Sears

**14. MOTHER'S MAIDEN NAME:** MARTHA Maderson

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) (If Yes, give war or dates of service) YES 1918

**16. SOCIAL SECURITY NO.:** 070-07-8927

**17. INFORMANT & ADDRESS:** MRS. CARL SEARS 212 E. FRANKLIN ST. SILVER SPRING, MD.

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) RESPIRATORY FAILURE | 6 HOURS. 1 HOURS. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last | (b) THROMBOSIS CEREBELAR ARTERY. DUE TO | 6 WEEKS. |
| | (c) CEREBRAL ARTERIOSCLEROSIS. DUE TO | |

I. 532

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:**

**19b. MAJOR FINDINGS OF OPERATION:**

**20. AUTOPSY?** Yes ☐ No ☒

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JAN. 7, 1953, to JAN. 21, 1953, that I last saw the deceased alive on JAN. 21, 1953, and that death occurred at 1:45 A.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

James A. Roberts M.D. 8901 COLESVILLE ROAD SILVER SPRING, MD. JAN 21, 1953

**23. BURIAL, CREMATION, REMOVAL (Specify):** Burial

DATE THEREOF 1/23/53

NAME OF CEMETERY OR CREMATORY Arlington National Cemetery

LOCATION (City, town, or county) (State) Arlington, Virginia

DATE REC'D BY LOCAL REG. 1/26/53

REGISTRAR'S SIGNATURE Bessie M. Hirschbeck

**24. FUNERAL DIRECTOR** Warner E. Tumbleson

ADDRESS 8434 Georgia Ave. Silver Spring, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 213

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN) Potomac
LENGTH OF STAY (in this place) 2 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rockville R.7.D.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Potomac
STREET ADDRESS (If rural, give location) Rockville, R.7 D

3. NAME OF DECEASED: (Type or Print) (First) Lettie (Middle) Sewell (Last)

4. DATE OF DEATH: (Month) (Day) (Year) Jan. 26th 1953

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Oct. 20, 1878

9. AGE last birthday: 75 yrs. IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: James Brown

14. MOTHER'S MAIDEN NAME: Eliza - Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S ADDRESS: Mrs Eliza Campbell - Rockville, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

480 X

Immediate cause (a) Lobar pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) influenza

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION: 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 24, 1953, to Jan. 26, 1953, that I last saw the deceased alive on Jan. 24, 1953, and that death occurred at 8 A.M., from the causes and on the date stated above.

SIGNATURE E. D. Hartley M.D. (DEGREE OR TITLE) Rockville Maryland (ADDRESS) DATE SIGNED

26. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF 1/29/53 — NAME OF CEMETERY OR CREMATORY Lincoln Park — LOCATION (City, town, or county) Rockville, Md (State)

DATE REC'D BY LOCAL REG. 2-12-53 — REGISTRAR'S SIGNATURE Helen L. Eckenfelder

24. FUNERAL DIRECTOR Robert L. Snowden, Rockville Md — ADDRESS

VS. A15 51

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 223

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16 51

**1. PLACE OF DEATH:**
COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Takoma Park
LENGTH OF STAY (in this place) 16 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS 804 Maplewood Avenue

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE Md. COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
STREET ADDRESS (If rural, give location) #1 Montgomery Avenue

**3. NAME OF DECEASED: (Type or Print)** (First) LOTTIE (Middle) LEE (Last) SMITH.

**4. DATE OF DEATH:** (Month) Jan. (Day) 7 (Year) 1953.

**5. SEX:** Female

**6. COLOR OR RACE:** White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):** Widowed

**8. DATE OF BIRTH:** May 4, 1876

**9. AGE last birthday:** 76 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Homemaker

**10b. KIND OF BUSINESS OR INDUSTRY:** At Home

**11. BIRTHPLACE** (State or foreign country): Williamstown, Michigan

**12. CITIZEN OF WHAT COUNTRY?** U. S. A.

**13. FATHER'S NAME:** Quincy Adams Smith

**14. MOTHER'S MAIDEN NAME:** Carrie ?

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) No (If Yes, give war or dates of service)

**16. SOCIAL SECURITY NO.:**

**17. INFORMANT & ADDRESS:** Herbert D. Smith, 11 Pine Ave. Tak Park. Md.

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

| | | | Interval Between Onset and Death |
|---|---|---|---|
| Immediate cause | (a) Uremia | | 2 weeks |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last | DUE TO (b) Arteriosclerosis Generalized | | 10 years |
| | DUE TO (c) | | |

45 ?

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:** **19b. MAJOR FINDINGS OF OPERATION:** **20. AUTOPSY?** Yes ☐ No ☒

**21. ACCIDENT / SUICIDE / HOMICIDE (Specify)** — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 1-, 1946, to 7 Jan., 1953, that I last saw the deceased alive on 6 Jan., 1953, and that death occurred at 7-1 m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS — DATE SIGNED
M. Pullen M.D. 7112 Willow Ave Takoma Park, Md. 7 Jan 1953.

**23. BURIAL, CREMATION REMOVAL (Specify):** Cremation — DATE THEREOF Jan. 10, 1953 — NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory — LOCATION (City, town, or county) (State) Prince George County, Md.

DATE REC'D BY LOCAL REG. Jan 7-1953 — REGISTRAR'S SIGNATURE J. Milton Dodd

**24. FUNERAL DIRECTOR** — ADDRESS J. Arthur Walters, 254 Carroll St. NW Takoma Park, DC

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 223

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN Takoma Pk, Md — LENGTH OF STAY (in this place) 6 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Wash. San & Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring, Md.
STREET ADDRESS (If rural give location) 9306 Caroline Ave

3. NAME OF DECEASED: (Type or Print) (First) Samuel (Middle) F. (Last) Smith

4. DATE OF DEATH: (Month) 1 (Day) 22 (Year) 1953

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W

8. DATE OF BIRTH: 8-6-88

9. AGE last birthday: 64 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Policeman

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Washington, DC

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Arthur B. Smith

14. MOTHER'S MAIDEN NAME: Lulie A. Taylor

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 577-34-1456

17. INFORMANT & ADDRESS: Mrs. Mary Regan, 9306 Caroline Ave., Silver Spring, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

420.1

Immediate cause (a) Coronary thrombosis & myocardial infarction — 48 hrs

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Hypertensive cardiovascular disease

DUE TO

(c) Generalized arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Aspirated evidence of coronary insufficiency.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 15, 1952, to Jan 22, 1953, that I last saw the deceased alive on Jan 22, 1953, and that death occurred at 9:26 P.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) Ernest E Harmon M.D. — ADDRESS 9301 Colesville Rd. Silver Spring — DATE SIGNED 1-26-53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 1/26/53 — NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery — LOCATION (City, town, or county) (State) Washington, D. C.

DATE REC'D BY LOCAL REGISTRAR Jan. 28-1953 — REGISTRAR'S SIGNATURE J. Milton Dodd

24. FUNERAL DIRECTOR Leonard Sumpter — ADDRESS 8434 Ga. Ave. Silver Spring, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
COUNTY: MONTG. — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN: BETHESDA
LENGTH OF STAY (in this place): 11 HRS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: SUBURBAN HOSP. TOL.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE: MD. — COUNTY: MONTG.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CHEVY CHASE
STREET ADDRESS (If rural give location): 3918 EAST-WEST HIGHWAY

**3. NAME OF DECEASED:** (Type or Print) (First) WINONA (Middle) LOTT (Last) SMITH

**4. DATE OF DEATH:** (Month) Jan. (Day) 20 (Year) 1953

**5. SEX:** F.

**6. COLOR OR RACE:** W

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):** MARRIED

**8. DATE OF BIRTH:** 6-25-09

**9. AGE last birthday:** 43 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION.** Give kind of work done during most of working life, even if retired): HOUSEWIFE

**10b. KIND OF BUSINESS OR INDUSTRY:** HOME

**11. BIRTHPLACE** (State or foreign country): NEW YORK N.Y.

**12. CITIZEN OF WHAT COUNTRY?** U.S.A.

**13. FATHER'S NAME:** CLARENCE PORTER

**14. MOTHER'S MAIDEN NAME:** HAZEL LOTT

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) (If Yes, give war or dates of service)

**16. SOCIAL SECURITY NO.:**

**17. INFORMANT & ADDRESS:** HUSBAND. WAYNE H. SMITH - 3918 EAST-WEST Highway

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset And Death: 16 hrs.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. 331.1
DUE TO (b) Hypertension — 18 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:** —

**19b. MAJOR FINDINGS OF OPERATION** —

**20. AUTOPSY?** Yes ☐ No ☒

**21.** ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar. 19 46, to Jan. 20, 19 53, that I last saw the deceased alive on Jan. 20, 19 53, and that death occurred at 11:40 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Philip H. Varner M.D. ADDRESS Chevy Chase Md. DATE SIGNED Jan. 20, 53

**23.** BURIAL, CREMATION, REMOVAL. (Specify) Burial

DATE THEREOF 1/23/53

NAME OF CEMETERY OR CREMATORY Arlington Nat'l

LOCATION (City, town, or county) (State) Arlington, Va.

DATE REC'D BY LOCAL REGISTRAR 1/21/53

REGISTRAR'S SIGNATURE Ernest Swanson

**24.** FUNERAL DIRECTOR ADDRESS The S.H. Hines Co - 2901 - 14th St N.W. Washington D.C.

VS. A15

JAN
BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda; MARYLAND; LENGTH OF STAY (in this place) 2 days.; HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE; COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington D.C.; STREET ADDRESS (If rural give location) 4618 38th St. N.W. ✓

3. NAME OF DECEASED: (First) William (Middle) — (Last) Studds

4. DATE OF DEATH: (Month) Jan (Day) 6 (Year) 1953

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower

8. DATE OF BIRTH: March 3, 1859

9. AGE last birthday: 93 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired) Telephone repair man.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Alexandria, Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Julian A Studds 4618 38th St N.W. Washington DC

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0

Immediate cause (a) Senile Generalized Arteriosclerosis

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

Interval Between Onset And Death

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Post Viral Infection — 1 month

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. ,1952, to 1-6, 1953, that I last saw the deceased alive on 1-6 , 1953, and that death occurred at 2:55 PM from the causes and on the date stated above.

SIGNATURE P.P. Andrews (Degree or title) M.D. ADDRESS Washington D.C. DATE SIGNED 1-6-53

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF 1/9/53 | NAME OF CEMETERY OR CREMATORY Union Cem. | LOCATION (City, town, or county) Alexandria, Va (State)

DATE REC'D BY LOCAL REGISTRAR 1/7/53 | REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR H. H. Chambers ADDRESS 5801 Cleveland Ave Kensington Md

VS. A15

JAN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH:**

COUNTY: Montgomery — MARYLAND

CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town): — LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS (If rural give location): Pinecrest Sanitarium

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

STATE: Washington, D. C. — COUNTY:

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: WASHINGTON DC

STREET ADDRESS (If rural give location): 4505 46th St NW

| 3. NAME OF DECEASED: (Type or Print) | (First) | (Middle) | (Last) | 4. DATE OF DEATH: (Month) | (Day) | (Year) |
|---|---|---|---|---|---|---|
| | J | Clarke | Swayze | Jan. | 28 | 1953 |

| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE Last birthday: yrs. | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Widowed | 12-29-1876 | 76 | | 29 |

| 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Lawyer | Govt. | Kansas | U.S.A. |

| 13. FATHER'S NAME: | 14. MOTHER'S MAIDEN NAME: |
|---|---|
| J. Clarke Swayze | Jennie M. Erwin |

| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | 16. SOCIAL SECURITY No: | 17. INFORMANT & ADDRESS: |
|---|---|---|
| | | Mr. John M. Swayze, 4505 46th St. N.W. |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset And Death |
|---|---|---|
| Immediate cause | (a) Cerebral thrombosis | 1 month |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. | (b) DUE TO Arteriosclerosis + hypertension | 15 yrs |
| | (c) DUE TO | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. CVA (2 months ago)

| 19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑ |
|---|---|---|
| | | |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from ....., 1937, to 28 Jan, 1953, that I last saw the deceased alive on 24 Jan, 1953, and that death occurred at 9 P.M., from the causes and on the date stated above.

| SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|
| Richard B Castell | Mayflower Hotel | 28 Jan 53 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1/31/53 | Rock Creek | Washington DC |

| DATE REC'D BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 1/30/53 | [illegible] | Jos. Gawler's Sons | 1756 Penn. Ave. N.W. |

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1041 Manakee St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington.
STREET ADDRESS (If rural, give location) 1041 Manakee St.

3. NAME OF DECEASED (Type or Print): (First) Ralph (Middle) J (Last) Sweet
4. DATE OF DEATH: (Month) Jan. (Day) 10, (Year) 1953.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single
8. DATE OF BIRTH: Apr. 11, 1951
9. AGE last birthday: 1 yrs. If under 1 year: Months 8 Days 29 (If under 24 hrs.: Hours Min.)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Wash. D.C.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: J. W. Sweet.
14. MOTHER'S MAIDEN NAME: Leona L. Powers.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT AND ADDRESS: J. W. Sweet. Kensington, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardiac Collapse.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Diarrhoea = Vomiting = Virus Infection

(c)

5 1.5

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7 Jan., 1953, to 10 Jan., 1953, that I last saw the deceased alive on 9 Jan., 1953, and that death occurred at 5:30A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Robert A. Butz. M.D. ADDRESS 9128 Woodland Drive Silver Spring Md. DATE SIGNED 10 Jan 53

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: 1/12/53
NAME OF CEMETERY OR CREMATORY: Cedar Hill
LOCATION (City, town, or county) (State): Mt. Geo. Cy. Md.

DATE REC'D BY LOCAL REG.: 1/12/53
REGISTRAR'S SIGNATURE: (Title)
24. FUNERAL DIRECTOR: W W Chambers Co ADDRESS: 3072 M St NW WASH. D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH:**
COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE Maryland — COUNTY Montg.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
STREET ADDRESS (If rural give location) 1804 Alcan Drive

**3. NAME OF DECEASED:** (Type or Print) (First) William (Middle) Neal (Last) Tracewell

**4. DATE OF DEATH:** (Month) Jan. (Day) 24, (Year) 1953

**5. SEX:** male

**6. COLOR OR RACE:** white

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):** Widowed

**8. DATE OF BIRTH:** April 10, 1871

**9. AGE Last birthday:** 81 yrs. IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours / Min.

**10a. USUAL OCCUPATION** Give kind of work done during most of working life, even if retired) Retired Clerk-U.S.Treasury

**10b. KIND OF BUSINESS OR INDUSTRY:**

**11. BIRTHPLACE** (State or foreign country): Kansas

**12. CITIZEN OF WHAT COUNTRY?**

**13. FATHER'S NAME:** William Tracewell

**14. MOTHER'S MAIDEN NAME:** --

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) (If Yes, give war or dates of service) no

**16. SOCIAL SECURITY NO.:** no

**17. INFORMANT & ADDRESS:** Leighton Tracewell 1804 Alcan Dr. Silver Spring, Md.

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Arterio-sclerotic heart disease — Interval Between Onset And Death: 3 yrs.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b)

DUE TO (c)

42.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:** **19b. MAJOR FINDINGS OF OPERATION** **20. AUTOPSY?** Yes ☐ No ☒

**21.** ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/8, 1951, to 1/23, 1953 that I last saw the deceased alive on 1/23, 1953, and that death occurred at 3:55 A.M.; from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Harold F. McCann M.D. 3008-14th St. N.W. Wash. 9, D.C. 1/24/53.

**23. BURIAL, CREMATION, REMOVAL** (Specify) Burial — DATE THEREOF 1/26/53 — NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery — LOCATION (City, town, or county) (State) Prince Georges Co., Md.

DATE REC'D BY LOCAL REGISTRAR 1/27/53 — REGISTRAR'S SIGNATURE Frances Potter

**24. FUNERAL DIRECTOR** The S. N. Hines Co. — ADDRESS 2901 14th St. N.W. Washington 9, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospital 8600 Old Georgetown Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington
STREET ADDRESS (If rural give location) 3924 Baltimore St.

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) B (Last) Tremearne

4. DATE OF DEATH: (Month) (Day) 4 (Year) 1953

5. SEX: Female — 6. COLOR OR RACE: White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed — 8. DATE OF BIRTH: Dec. 12 1867 — 9. AGE last birthday: 85 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life even if retired: Housewife — 10b. KIND OF BUSINESS OR INDUSTRY: — 11. BIRTHPLACE (State or foreign country): Canandaigua New York — 12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Augustus S. Burridge — 14. MOTHER'S MAIDEN NAME: Pauline A. Raymond

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service) — 16. SOCIAL SECURITY No.: None — 17. INFORMANT & ADDRESS: Dr. Katherine Lehman 3924 Baltimore Kensington Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

420.1

Immediate cause (a) Pulmonary Embolism

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) atrial Fibrillation Cirrhosis Liver
DUE TO (c) Thrombophlebitis Coronary Artery Disease

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION: None — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) No — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 21 1952, to Jan. 4 1953, that I last saw the deceased alive on Jan. 4 1953, and that death occurred at 5:08 A.M. from the causes and on the date stated above.

SIGNATURE Charles R. L. Hadley (Degree or title) M.D. — ADDRESS 9157 Ga. Ave. Wheaton Md. — DATE SIGNED Jan. 7 1953

23. BURIAL, CREMATION, REMOVAL (Specify) Cremation — DATE THEREOF Jan. 7 1953 — NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory — LOCATION (City, town, or county) Prince Georges Co. — (State) Md.

DATE REC'D BY LOCAL REGISTRAR 1/8/53 — REGISTRAR'S SIGNATURE Bessie M. Hamilton — 24. FUNERAL DIRECTOR Warner E. Pumphrey — ADDRESS Silver Spring, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Burtonsville — LENGTH OF STAY (In this place) 3 mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Monty
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Burtonsville
STREET ADDRESS (If rural, give location)

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Mary | Frances | Tyler | June | 30 | 1953 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Married | 3-30-'86 | 66 yrs. | | | | |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Clark
14. MOTHER'S MAIDEN NAME: Sarah Wilkeam

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT AND ADDRESS: John Tyler (Husband) Burtonsville, Md.

18. MEDICAL CERTIFICATION

| 19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 421 Immediate cause | (a) Coronary occlusion | Sudden |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | death |
| | (c) | |
| 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | |

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒ |
|---|---|---|
| | | |

| 21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME (Month) (Day) (Year) (Hour) OF INJURY | m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|---|
| | | | |

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|
| Francis J. Bracchant M.D. | Gaithersburg Md | 1-30-53 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 2/2/53 | Colesville Cemetery | Montgomery County, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 2/2/53 | Frances Potter | Wm. R. Humphrey | 8434 Georgia Ave. Silver Spring, Maryland |

Film G150 Items 11+23
1953

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information ■refully. The correct ■ especially important. Phy■cians: please write the causes of deat■ clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville
LENGTH OF STAY (in this place) 7 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Chestnut Lodge. Inc

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Wisconsin. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Appleton.
STREET ADDRESS (If rural, give location) ✓

3. NAME OF DECEASED (Type or Print): (First) Elizabeth. (Middle) Theresa. (Last) Stolz.
4. DATE OF DEATH: (Month) Jan (Day) 2 (Year) 1953

5. SEX: F
6. COLOR OR RACE: White.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: Oct. 3, 1874
9. AGE last birthday: 78 yrs. If under 1 year: Months 3 | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife.
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Milwaukee Wisconsin
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Michael. Stolz.
14. MOTHER'S MAIDEN NAME: Elizabeth Odenbrecht.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No.
16. SOCIAL SECURITY NO.: None.
17. INFORMANT AND ADDRESS: Mrs. Crosby Boyd, 5019 Lowell St. N.W. Wash. D.C.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) RECURRENT MAMMARY CARCINOMA

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) WITH DEHYDRATION AND MAL-

(c) NUTRITION

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. GENERALIZED ARTERIOSCLEROSIS.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED Whilo at Work ☐ Not Whilo At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JAN 1, 1953, to JAN 2, 1953, that I last saw the deceased alive on JAN 2, 1953, and that death occurred at 5:25 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Cecil C.H. Cullander, M.D. CHESTNUT LODGE INC ROCKVILLE, MD. JAN 2, 1953

23. BURIAL, CREMATION REMOVAL (Specify) ✓ Burial
DATE THEREOF Jan. 3, 1953
NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery
LOCATION (City, town, or county) (State) Washington D.C.

DATE REC'D BY LOCAL REG. 1-2-53
REGISTRAR'S SIGNATURE Helen V. Crawford Reg. D.
24. FUNERAL DIRECTOR
ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

214

Reg. Dist. No.....

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 818 Belvedere Boulevard

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
STREET ADDRESS (If rural, give location) 818 Belvedere Boulevard

3. NAME OF DECEASED (Type or Print): (First) Helen (Middle) Lott (Last) Walker

4. DATE OF DEATH: (Month) Jan. (Day) 7 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 1/22/01

9. AGE last birthday: 51 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary

10b. KIND OF BUSINESS OR INDUSTRY: Government

11. BIRTHPLACE (State or foreign country): Elnora, Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph H. Lott

14. MOTHER'S MAIDEN NAME: Jennie Schoch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS: Mrs. Eugene G. Flester, Jr.

18. MEDICAL CERTIFICATION 314 Fairmont St., Falls Church, Va.

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Coronary occlusion | Immediate |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Hypertensive Heart Disease | 7 yrs. |
| | (c) Congestive Heart Failure | 10 months. |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/6, 1946, to 1/9, 1953, that I last saw the deceased alive on 1/9, 1953 and that death occurred at 3:15 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John J. Finnegan MD 1746-K St. N.W. 1/7/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 1/9/53

NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

LOCATION (City, town, or county) (State): Suitland, Maryland

DATE REC'D BY LOCAL REG. 1/9/53

REGISTRAR'S SIGNATURE: Frances Potter

24. FUNERAL DIRECTOR: Warwick Pumphrey ADDRESS: 8434 Georgia Ave. Silver Spring, Maryland

Coroner Notified - will approve
John F. Finnegan, M.D.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 21-4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: MONTGOMERY

City or town: CRESTVIEW (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life Time

Hospital, institution, or street address where death occurred.

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: MARYLAND County: MONT.

City or town: CRESTVIEW (If outside city or town limits, write RURAL and give nearest town)

Street No.: 4809- BAYARD BLVD. (If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME:** ROSE MARIE WATERS

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Married |

6.(b) Name of husband or wife: Johnnie Waters

6.(c) If alive, give age: 28 years

7. Birth date of deceased (mo., day, yr.): 2-5-30

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 22 | | | ... hrs. ... min. |

9. Birthplace: WASHINGTON D.C. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Geo. W Killion

13. Birthplace: Mass.

MOTHER 14. Maiden name: Annie Thomas

15. Birthplace: Georgetown

16. Informant: Husband

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 26 1953 (month) (day) (year)

Cemetery or crematory: Arlington Natl.

Location: Arlington Va.

18. Funeral director: J. Alton DeVol

Address: 2224-W is. Ave.

19. 1-23 1953 Burial Permit (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Jan - 22 - 1953 at 11:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10 - 1952 to Jan 22 - 1953 and that I last saw her alive on Jan - 21 1953

| Immediate cause of death | | DURATION |
|---|---|---|
| | Glio-Blastoma of Brain Stem | 4 months |
| Due to | | |
| Due to | | |
| Other conditions | | |

(Include pregnancy within 3 months of death)

Major findings of operations: Craniotomy - Glio-Blastoma of Brain Stem Date of op. Aug 4 1952

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Hunt Taylor M.D. M. D. or other

Address: 3066 Connecticut Ave. Date signed 1-24-53

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda; MARYLAND LENGTH OF STAY (In this place) D.C.A; HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Mont; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville; STREET ADDRESS (If rural, give location) Westmore

3. NAME OF DECEASED (Type or Print): (First) Richard (Middle) (Last) Wayne

4. DATE OF DEATH: (Month) Jan (Day) 7 (Year) 1953

5. SEX: male

6. COLOR OR RACE: col

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: 4-22-1906

9. AGE last birthday: 46 yrs.; If under 1 year: Months; If under 24 hrs.: Days; Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Sanitation

11. BIRTHPLACE (State or foreign country): Washington. DC

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Vernon Wayne

14. MOTHER'S MAIDEN NAME: Harriett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY No.:

17. INFORMANT AND ADDRESS: Leonard Wayne

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Coronary occlusion | 1 hr. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) hypertension | 4 yrs |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: Frank J. Rozehart (Degree or title) M.D. ADDRESS: Gaithersburg md DATE SIGNED: 1-7-53

23. BURIAL, CREMATION OR REMOVAL: Burial; DATE THEREOF: 1/12/53; NAME OF CEMETERY OR CREMATORY: Mt Zion; LOCATION (City, town, or county) (State): Washington, DC

DATE REC'D BY LOCAL REG. 1/12/53; REGISTRAR'S SIGNATURE:

24. FUNERAL DIRECTOR: Robert L. Snowden ADDRESS: Rockville, Md

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct name is especially important. Physicians: Please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2nd Ave. & Grace Church Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 239 Prince George Street ✓

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) L. (Last) White

4. DATE OF DEATH: (Month) Jan. (Day) 29 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: 8/8/69

9. AGE last birthday: 83 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker (retired)

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Leesburg, Virginia

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Benjamin Stephen White

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Meade

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Miss Elizabeth W. Meade, 239 Prince Geo. St. Annapolis, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Thoracic hemorrhage due to crushing chest — Interval between onset and death: Sudden death

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Fracture 3rd dorsal Vertebrae

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Fracture both legs at wrist

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY street

(CITY OR TOWN) Silver Spring (COUNTY) Mont (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) Jan 29-53 6:30 p.m.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? Struck by auto

22. *I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: Frank O. Brostrom M.D. (Degree or title) ADDRESS: Frostburg Md DATE SIGNED: 1-29-53

23. BURIAL, CREMATION REMOVAL (Specify): Cremation — DATE THEREOF: 2/2/53 — NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Crematory — LOCATION (City, town, or county) (State): Prince George County, Md.

DATE REC'D BY LOCAL REGI 1/31/53 — REGISTRAR'S SIGNATURE: Frances [illegible]

24. FUNERAL DIRECTOR — ADDRESS: 8434 Georgia Ave. Silver Spring, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Forest Glen Villa

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE D.C. — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 1229 Crittendon St. N.W. ✓

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Lenore (Last) Whiting
4. DATE OF DEATH: (Month) Jan (Day) 2 (Year) 1953
5. SEX: Female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: Oct 23 1872
9. AGE last birthday: 80 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired school teacher
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Henry Whiting
14. MOTHER'S MAIDEN NAME: Mary L. Freeman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS: Nursing Home records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary occlusion — found dead in bed

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

420.1

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ___, Inspection X, Inquiry ___ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

Thomas J. Burchard M.D. Gaithersburg Md 1-2-53

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF 1-5-53 | NAME OF CEMETERY OR CREMATORY Emmanuel | LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR — ADDRESS
The S. H. Hines Co. 2901-14th St. N.W.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 215

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington; LENGTH OF STAY (In this place) 2 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS Holy Cross

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington; STREET ADDRESS (If rural, give location) 3711 Plyers Mill Rd

3. NAME OF DECEASED (Type or Print): (First) WILLIAM (Middle) WALTER (Last) WILLIAMSON

4. DATE OF DEATH: (Month) Jan. (Day) 9 (Year) 1953

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH: Nov. 12, 1863

9. AGE last birthday: 89 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Washington D C

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: J C Williamson

14. MOTHER'S MAIDEN NAME: Marion Hallett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: [illegible]

17. INFORMANT AND ADDRESS: Mrs Clifford Nicholson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Bronchopneumonia | 3 weeks |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Myocarditis, arteriosclerosis | 5 years |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 19 52 to Jan. 10, 19 53 that I last saw the deceased alive on Jan. 9, 19 53 and that death occurred at 6 A. m., from the causes and on the date stated above.

SIGNATURE: Wm A. Smithers (Degree or title) MD ADDRESS: Rockville, Md. DATE SIGNED: 1/10/53.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE THEREOF: Jan 13/53; NAME OF CEMETERY OR CREMATORY: Forest Lawn Cemetery; LOCATION (City, town, or county) (State): Rockville Md

DATE REC'D BY LOCAL REG.: Jan. 15, 1953; REGISTRAR'S SIGNATURE: Helen Schumpert Deb

24. FUNERAL DIRECTOR: Roy W Beall Jr Potomac Md ADDRESS

For James F Brundette Alverda G. Brake

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00713

# CERTIFICATE OF DEATH

Reg. Dist. No. 223

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH:**
COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Takoma Park
LENGTH OF STAY (in this place) 20 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Wash. Sanitarium & Hosp.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE Maryland — COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
STREET ADDRESS (If rural give location) 12605 Colesville Rd.

**3. NAME OF DECEASED:** (Type or Print) (First) George (Middle) Camden (Last) Windham

**4. DATE OF DEATH:** (Month) Jan. (Day) 25 (Year) 1953

| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH: | 9. AGE Last birthday: | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | married | 7-6-88 | 64 yrs. | | |

| 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Mont. Co. Police | Policeman | Montgomery Co., Md. | U.S.A. |

| 13. FATHER'S NAME: | 14. MOTHER'S MAIDEN NAME: |
|---|---|
| George T. Windham | Annie Johnson |

| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: | 17. INFORMANT & ADDRESS: |
|---|---|---|
| | | Wife. res. |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset And Death |
|---|---|---|
| Immediate cause (a) | Cerebral Thrombosis (Terminal) | 6 hrs. |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) | Subacute Bacterial Endocarditis ? Coronae ? vegetativa | 8 wks |
| DUE TO (c) | Hypertensive Heart Disease | 15 yrs |

443+

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis — 15 yrs

| 19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from May 15, 1938, to Jan 25, 1953, that I last saw the deceased alive on Jan 25, 1953, and that death occurred at 10 35 p.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | TIME SIGNED |
|---|---|---|---|
| Kenneth Vaughan | MD. | 934 Ellsworth Dr. Silver Spring | 1-25-53. |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | Jan 27 1953 | Rock Creek | Washington D.C. |

| DATE REC'D BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Jan 28-1953 | J. Milton Dodd | Hamer E Humphrey | Silver Spring Md |

RECEIVED
JAN 29 1953
BUREAU V. A.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS Form 8-51

**1. PLACE OF DEATH:**
COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
LENGTH OF STAY (in this place) 5 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS 700 Hudson Avenue Eventide Nursing Home

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE Va. COUNTY Loudoun Co
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Round Hill
STREET ADDRESS (If rural, give location)

**3. NAME OF DECEASED:** (First) Maud (Middle) (Last) Wynkoop

**4. DATE OF DEATH:** (Month) Jan. (Day) 1 (Year) 1953

**5. SEX:** Fe.

**6. COLOR OR RACE:** White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):** Single

**8. DATE OF BIRTH:** Aug. 1, 1879

**9. AGE last birthday:** 73 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired):

**10b. KIND OF BUSINESS OR INDUSTRY:**

**11. BIRTHPLACE** (State or foreign country): Loudoun County, Va.

**12. CITIZEN OF WHAT COUNTRY?** U. S. A.

**13. FATHER'S NAME:** Joseph Thomas Wynkoop

**14. MOTHER'S MAIDEN NAME:** Frances Elizabeth Dear

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) No (If Yes, give war or dates of service)

**16. SOCIAL SECURITY NO.:** None

**17. INFORMANT & ADDRESS:** Miss Lillian Wynkoop, 1517 Varnum St. N.W. D.C.

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Coronary Occlusion | Approx. 10 min. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last | DUE TO (b) Hypertensive Cardio-vascular Disease | years |
| | DUE TO (c) Generalized Arteriosclerosis | years |

420.1

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Arthritis of Spine; Contracture of rt. knee. years.

**19a. DATE OF OPERATION:**

**19b. MAJOR FINDINGS OF OPERATION:**

**20. AUTOPSY?** Yes ☐ No ☒

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY — M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 18, 1950, to Jan. 1, 1953, that I last saw the deceased alive on Dec. 12, 1952, and that death occurred at 7:30 P.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS — DATE SIGNED
Walter N. Mook M.D. 7701 Carroll Ave. Takoma Park, Md. 1-1-53

**23. BURIAL, CREMATION, REMOVAL** (Specify): — DATE THEREOF 1-1-53 — NAME OF CEMETERY OR CREMATORY — LOCATION (City, town, or county) (State) Washington DC

DATE REC'D BY LOCAL REG. Jan-5 1953 — REGISTRAR'S SIGNATURE J. Hilton Dodd

**24. FUNERAL DIRECTOR** — ADDRESS Deal Funeral Home Wash DC.

RECEIVED
JAN 6 1953
BUREAU V. S.

Authorization To issue this death certificate granted by the Montgomery County Medical Examiner.

William M. Mork, M.D.